The Tavistock and Portman NHS
NHS Foundation Trust

Board of Directors Part One

Agenda and papers
of a meeting to be held in public

2.00pm–4.40pm
Tuesday 23rd June 2015

Board Room,
Tavistock Centre,
120 Belsize Lane,
London, NW3 5BA

BOARD OF DIRECTORS (PART 1)

Meeting in public
Tuesday 23rd June 2015, 14.00 – 16.40
Board Room, Tavistock Centre, 120 Belsize Lane, London NW3 5BA

AGENDA

PRELIMINARIES				
1.	**Chair's Opening Remarks** Ms Angela Greatley, Trust Chair		Verbal	-
2.	**Apologies for absence and declarations of interest** Ms Angela Greatley, Trust Chair	To note	Verbal	-
3.	**Minutes of the previous meeting** Ms Angela Greatley, Trust Chair	To approve	Enc.	p.1
3a.	**Outstanding Actions** Ms Angela Greatley, Trust Chair	To note	Enc.	p. 10
4.	**Matters arising** Ms Angela Greatley, Trust Chair	To note	Verbal	-
REPORTS & FINANCE				
5.	**Trust Chair's and NEDs' Report** Non-Executive Directors as appropriate	To note	Verbal	-
6.	**Chief Executive's Report** Mr Paul Jenkins, Chief Executive	To note	Enc.	p. 11
7.	**Finance & Performance Report** Mr Simon Young, Deputy Chief Executive & Director of Finance	To note	Enc.	p. 14
8.	**Training and Education Report** Mr Brian Rock, Director of Education & Training; Dean	To note	Enc.	p. 22
9.	**Service Line Report, GIDS** Dr Polly Carmichael, Director of GIDS	To note	Enc.	p. 26
10.	**Annual Safeguarding Report** Dr Rob Senior, Medical Director	To note	Enc.	p. 60
STRATEGY				
11.	**Board Objectives** Ms Angela Greatly, Chair; Mr Paul Jenkins, CEO	To approve	Enc.	p. 69
12.	**Update on Chair Recruitment** Mr Gervase Campbell, Trust Secretary	To note	Enc.	p. 73
13.	**Identity Badges** Ms Louise Lyon, Director of Q&PE	To discuss	Enc.	p. 76

CORPORATE GOVERNANCE				
14.	**2nd Monitor Self-Certificate** Mr Simon Young, Deputy Chief Executive & Director of Finance	To approve	Enc.	p. 80
15.	**Audit Committee Terms of Reference** Mr David Holt, Audit Chair	To approve	Enc.	p. 85
16.	**Scheme of Delegation of Powers Review** Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p. 95
PATIENT STORY				
17.	**Patient Story - GIDS** Ms Claire Shaw, Patient Story Lead	To discuss	Verbal	-
CONCLUSION				
18.	**Any Other Business**		Verbal	-
23.	**Notice of Future Meetings** • Thursday 25th June 2015: Council of Governors' Meeting 2.00pm – 5.00pm, Board Room • Tuesday 14th July 2015: Leadership Group 12.00pm – 5.00pm, Lecture Theatre • Tuesday 28th July 2015: Board of Directors' Meeting 2.00pm – 5.00pm, Board Room		Verbal	-

Board of Directors

Meeting Minutes (Part One)
Tuesday 26th May 2015, 2.00 – 5.00pm

Present:			
Ms Angela Greatley Trust Chair	Prof. Dinesh Bhugra NED	Ms Jane Gizbert NED	Mr David Holt NED
Mr Paul Jenkins Chief Executive	Ms Louise Lyon Director of Quality, Patient Experience and A&FS	Dr Ian McPherson Non-Executive Director & Vice Chair of Trust	
Ms Edna Murphy NED	Dr Rob Senior Medical Director	Mr Simon Young Deputy CEO & Director of Finance	
Attendees:			
Mr Gervase Campbell Trust Secretary (minutes)	Dr Elena Rowland Governor	Dr Andy Wiener Associate Clinical Director CYAF (item 10)	Ms Laure Thomas Communications and Marketing Director (item 14)
Ms Susan Thomas HR Director (item 15)	Mr Anthony Newell Patient Experience Manager (item 21)	Ms E and her children (item 21)	
Apologies:			
Ms Lis Jones Nurse Director	Mr Brian Rock Director of Education and Training, Dean	Dr Rita Harris CYAF Director	

Actions

AP	Item	Action to be taken	Resp	By
1	3	Minor changes to be made to the minutes	GC	Immd.
2	6	Circulate lessons learnt from Essex CAMHS bid	PJ	July
3	14	Circulate access agreement for radio documentary to the board.	LT	June
4	17	Update on 'Freedom to Speak Up' and worries and concerns to return to board	GC	Sept.

1. Trust Chair's Opening Remarks

Ms Greatley opened the meeting.

2. Apologies for Absence and declarations of interest

Apologies as above.
There were no declarations of interest specific to this meeting.
Ms Greatley declared her new appointment as Associate NED at Barts Health.

3. Minutes of the Previous Meeting

AP1 The minutes were approved subject to minor amendments

4. Matters Arising

Action points from previous meetings:
AP1 – (minor changes to minutes) – completed.
AP2 – (addition of NEDs to 'everyone' email list) – Mr Campbell explained that IT were working on this.
AP3 – (circulate waiting time data) – it was noted that this had not been completed.
AP4 – (produce summary sheets for each service) – Ms Lyon was working on this.

Outstanding action points:
OAP 3,6,2,4 — it was noted that these had all been completed.
OAP6 – (PPI paper) – it was agreed that this would be combined with the strategy paper in July.

There were no further matters arising.

5. Trust Chair and NEDs' Report

Ms Greatley noted that she had attended a Kings Fund Event, 'First 100 Days', looking at integration, which had generated a lot of interest.

Prof. Bhugra reported that he had attended a NED networking event where the 'Providing for the Future' report had been discussed, and commented that one idea from it was the promotion of 'Yes' events, which were positive events patients must experience, as opposed to 'Never' events. Mr Jenkins commented that we were doing something similar in the One Hackney service, with a set of 'Always' events.

Ms Gizbert reported that she had visited the Gloucester House Day Unit, and it has been a revelation to watch the staff there at work.

6. Chief Executive's Report

Mr Jenkins noted that failure to secure the Essex bid had been disappointing, but they had done credibly and there would be a lot to learn from the feedback, and the Strategic and Commercial board would be looking at it critically. The NEDs discussed the importance of learning from the experience, and it was agreed that a summary of the lessons would be circulated to the board.

AP2

He commented that the modular building was on track for completion on schedule, and should be open in two weeks. The feedback from staff at Centre Heights was that they were looking forward to being more centrally located.

The Board **noted** the report.

7. Finance & Performance Report

Mr Young introduced the report, commenting that a good start had been made to the year. He noted that NHS England had now paid the outstanding cost of the GIDS over-performance over the first 3 quarters of the previous year, section 2.4 of the report.

Mr Holt queried the figures in the forecast column. Mr Young explained that these were the same as the revised budget variance, and where higher clinical income was allowing increases to budgets the difference was being kept in the reserve until it was clear it would not be required.

The Board **noted** the report.

8. Training and Education Report

Mr Jenkins summarised that there had been significant progress, but also clarity over the scale of work needed to get the systems and processes up to speed. He highlighted five areas of the report: the joint meeting with Essex and UEL had gone well, with an agreement that all shorter courses would transfer from 15/16, and a more gradual transition for longer doctoral courses.

The programme board was concentrating on the recruitment targets for 15/16, and the earlier start combined with management scrutiny should address the continuing issues with marketing and process management. Targets for the next two years of the strategic plan, and the level of appetite for expansion over the next five, were also being considered.

The regional strategy was progressing, with a focus on places with existing bases such as the Northern School, but also the possibility of delivering courses from the UEL campus in East Anglia.

The ICT procurement was progressing, and the team should be able to bring a report on this to the July board.

Four of the six portfolio manager posts in DET had been filled, and another round of recruitment, opened up to external candidates, was scheduled to fill the last two places.

Prof. Bhugra noted that there was a strong demand for psychotherapy supervision internationally, and it was an opportunity for the Trust. Mr Jenkins agreed, but suggested their current priority had to be the national contract, but it would be included at the right point of the two year strategy. Ms Lyon commented that they were already looking at different ways to deliver services, and to solve the issues about remote supervision, which would set them in a strong position for international work in the

future.

The Board **noted** the report.

9. CQSG Report, Quarter 4, 2014/15

Dr Senior introduced the report, noting that it was the draft notes from the last meeting. He reminded the board that this would be the last report under the old Terms of Reference and workstream structure, going forward there would be a combined quality workstream led by Louise Lyon, whilst CQC preparations would be covered within the Corporate Governance workstream.

Mr Holt noted that the Audit Committee found the report very useful in terms of identifying risk and where to direct internal audit, and there was likely to be a focus on outcome monitoring over the coming year. Ms Greatley commented that sitting on both the CQSG and Audit Committees she was able to feed back the recognition that the way the ratings were tested during the CQSG meeting was a good practice.

The Board **noted** the report.

10 Service Line Report – Camden CAMHS

Dr Wiener introduced the report by highlighting the Minding the Gap project, which works in partnership to aid the transition of young people between CAMHS and Adult services. The service involves a large culture change in organisations, but is widely supported, and fits with the values of the contemporary psychosocial approach. Recruitment to the project was underway, and an interim team of assistant psychologists and family therapists from the Trust was in place.

Dr Wiener went on to review the demand situation, noting that there had been an increase of 11% in subsequent appointments in North Camden, whilst South Camden had seen large increases for both 1st and subsequent appointments, and these were changes that could be felt on the ground. Based on the modelling done for recent bids the service should be able to cope, and they were monitoring the number of appointments per half day to keep this under review. They would be implementing the Thrive model, giving evidence based short implementations where appropriate, whilst reserving longer term treatment for areas it was required, such as chronic depression and self-harm. For this to work it meant giving a holistic offer with CAMHS as a small part of a larger whole, and they were working with local authorities, who were in favour of it, to develop one joint care plan for each patient.

Dr McPherson noted that the Thrive model was dependent on other agencies buying in and if the local authorities were not engaged it would be hard to withdraw the treatments that had been identified as unhelpful. Dr Wiener commented that the commissioners supported this, and that he sat on the Resilient Family Team meetings and was engaging with other panels so that they could work together to create one care plan involving multiple agencies. He acknowledged that there were more challenges engaging with social services, but he had met with them to discuss cases that were not raised to the level of child protection, so that both sides were clearer about what each could realistically do.

Mr Holt noted that section 6 showed demand exceeding the plan under the block contract, and asked how the service judged when levels were safe. Dr Wiener explained the value of the appointments per half-day report, which was reviewed quarterly, and was currently at safe levels with time for liaison, supervision and team meetings built in. He commented that with the introduction of CareNotes they would have even better information on non-clinical related elements of the workload. Dr Senior added that they considered not just quantity, but the increasing complexity of cases, about which they had some data.

The Board **noted** the report.

11 Annual Report and Accounts

Mr Campbell reviewed the background to the annual report and accounts, tabled the list of amendments to the circulated version, and explained the approval requirements. The board discussed the text: Ms Gizbert suggested that an additional line on the responsibility for communication, marketing and reputation of the Director of Education and Training be added to the governance section; it was noted that in table 2 of the Staff Survey chapter there were a set of figures where there needed to be explanation that they were scored out of 5.

Mr Young addressed the accounts, noting that they had been reviewed by the audit committee and approved by the external auditors, who would give their formal approval once the board gave its approval. Mr Holt noted that the Audit Committee had tested the balance sheet and the position on valuation of assets, which had been identified as a key area. They had also tested assumptions and management judgements around income recognition and various other issues that had been discussed at the board previously.

Mr Young explained the purpose of the Letters of Representation, and that

he could confirm the contents of the financial one, whilst Ms Lyon had assured the Audit Committee regarding the Quality Report one. He clarified the purpose and meaning of the going concern statement for the validity of accounts, and assured the board that the Trust was a going concern.

The Board **approved** the Annual Report and Accounts, including the requested changes and the tabled amendments. The Board **approved** the Annual Governance Statement in the report. The Board **approved** the Letters of Representation.

12 Annual Quality Report

Dr McCarthy Woods introduced the report, noting that since the board had reviewed the draft the feedback from stakeholders had been added. She confirmed that the process by which the quality report had been written met the required criteria, and the auditors had given their assurance on this. Ms Greatley commented that the process had been thorough, and it was very good that the governors had been involved in it and in thinking about the targets. She noted that it was also a readable document, and gave her thanks for an excellent piece of work. The Board discussed the positive feedback from the commissioners and Health Watch.

The Board **approved** the Quality Report, and the Statement of Director's Responsibilities within in.

13 Developing a two year strategic plan

Mr Jenkins introduced his proposal for a two year strategic plan, which would give a clear direction of travel, and refresh the Shaping Our Future document. As this was not a Monitor requirement, the Trust was free to format it as they pleased, and he would consult on it with staff and Governors. He added that the appendix contained the draft Mission and Values statement that had come from the working group, and that the board would have time to discuss the details of both at the June Directors Conference.

The board debated the value of a two, versus a three year strategy, and whether the consultation should be more clearly about *how* to achieve the strategic aims. There was consideration of the urgency of the challenges facing the Trust, and the benefits of working within a timescale where the context was known with some granularity. There was a discussion of whether the Mission and Values statement should be circulated separately from the strategy; Mr Holt noted that this was the first time board members who did not sit on the working group had seen that document, and it was agreed that it should be made clearer that this was a draft and the board would have further opportunity to review it after the consultation. It was agreed that the paper, once tightened up to reflect the comments made, should be circulated to governors in advance of the council meeting.

The Board **noted** the report.

14 Documentary Film Proposal

Ms Laure Thomas summarised the report, summing up the benefits for demystifying the issues, and noting that the access agreement had been approved by all parties involved, and now included an extra clause allowing the Trust to terminate the project if we had any significant concerns about service users. She noted that there was also a separate radio documentary in process that would be coming out before the film, and would likely be aimed at a different audience. She noted that Century films were drafting something for us about the scope of the documentary, the process, and the involvement of clinicians in being a portal and protection for all patients, and this would be communicated to staff once the project was approved.

The board discussed the proposal, with the NEDs noting that the good explanation of the benefits for patients in the access agreement was missing from the proposal, that there needed to be more clarity about who would be responding to media enquiries, and that the radio documentary had been discussed briefly at the April meeting, but had not come to the board for approval as there was less exposure than with Channel 4. It was agreed that the access agreement for the radio programme should be circulated to the board, and staff should be briefed.

AP3

The Board **approved** the proposal to move to production.

15 HR Action Plan from 2013 Staff Survey - update

Ms Susan Thomas gave the background to the work, which was the concern of the board over the bullying and harassment result in the 2013 staff survey, which had led to a follow up survey in CAMHS, and then the development of an action plan to tackle the issue. She reported on the progress against the action plan, which included promotion of openness in a number of forums, raising the issue in INSET day training, and the set-up of the fully independent support helpline. She noted that there had been no calls to the external line, but the newly re-launched Staff Advice and Consultation Service (SACS) had seen a lot of activity from people who wanted to talk about various issues, and it was encouraging they felt able to do this internally.

Ms Thomas noted that the 2014 staff survey had shown a great improvement in the scores for bullying and harassment, and we now scored lower than the national average.

Ms Gizbert clarified the difference between the helpline and the SACS, and Dr McPherson asked about the internal mediation service, which Ms Thomas confirmed was run mostly by HR staff, and was being used mostly in repairing broken down relationships and also in resolving situations before they became tribunal cases. Ms Greatley commented that an improved intranet site which clearly laid out the various options available might help

make them clearer and improve their use.

The Board **noted** the report.

16 Duty of Candour & FPPT – action plan update

Mr Campbell introduced the report, noting that it was an update on the action plan that had been presented in February, and highlighting the key points it contained.

Mr Young noted that the Anti-Fraud procedure contained the name of the Audit Chair as a route for raising concerns in addition to counter-fraud, or Director of Finance routes. Ms Lyon commented that having names for contacts more widely in policies, rather than roles, would help staff made the connection more easily.

Dr McPherson noted the difficulties with publishing quarterly summaries of complaints, but asked if there might still be value in doing this even if they had to be very general for anonymity. It was agreed to refer this to Ms Key for reconsideration. Ms Lyon noted that she was currently reporting complaints quarterly to our CQC Inspector.

The Board **noted** the report.

17 'Freedom to Speak Up' report

Mr Campbell introduced the report, explaining that it addressed the recommendation of the report by Sir Robert Francis which looked at whistleblowing and how to create an open culture within the NHS. The board discussed the recommendations, and the various appointments for receiving concerns. Mr Holt emphasized the importance of distinguishing between complaints and whistleblowing, to help encourage receiving both. Dr Senior commented that the work on whistleblowing was complemented by the ongoing work in looking at capturing lower level worries and concerns, and that NED involvement there would be valuable in giving an external perspective. It was agreed that this was an important topic and an update should return to the board in September.

AP4

The Board **noted** the report.

18 Jimmy Savile Recommendations Report

Mr Campbell introduced the report giving the background and explaining the draft action plan that would be returned to Monitor once approved. Ms Greatley noted that the language within the draft action plan needed to be tightened up and more detail given for some of the items. Mr Holt raised the question of ID badges, and access to the site more generally and Ms Lyon explained that the management team were looking at the issue and would be bringing a paper to the board shortly.

The Board **approved** the action plan, subject to the amendments discussed.

19 Annual Governance Statement (1)
Mr Campbell explained the purpose of the statement, and the assurance the board had in approving it.

The Board **approved** the statement.

20 Use of Trust Seal
Mr Campbell explained that the Trust Seal had been used for a change to the contract for the Westminster Family Service.

The Board **approved** the use of the seal.

21 Patient Story
The board were visited at the start of their meeting by Ms E, her son F (12) and her daughter G (11); the children were both patients of the Trust. The children explained something of their experience in coming to the Trust, and their experiences with the clinicians they had seen. The NEDs drew out some of the things they would like to see done differently, which included a Minecraft server for all the children at the Tavistock to use, and talked about how it was to leave school each week to come in for their appointments.

Ms E explained that she also received therapy from the Trust once a week, and it was a great space to talk about her children and other topics. She commented that you could feel isolated as a parent, and wondered if there was a way to raise the profile of the opportunities for joining groups. She commented that the second time they had been referred it had taken 3 months to be seen whilst the service lined up the best person, and whilst she understood the delay and had received an explanation in advance, some parents might find it helpful to have someone they could call in that situation. She noted that having the Trust liaise with the school was essential, and the Trust needed to be proactive in doing this.

Ms Greatley thanked all three for coming and sharing their experiences with the Trust.

22 Any Other Business & Notice of Future Meetings.
The Board noted the future meetings; there was no other business.

Part one of the meeting closed at 5.00pm

The Tavistock and Portman NHS
NHS Foundation Trust

Action Point No.	Originating Meeting	Agenda Item	Action Required	Director / Manager	Due Date	Progress Update / Comment
6	Feb-15	14. Patient Story Review	Paper on PPI development to come to the board	Paul Jenkins	Jun-15	To be combined with strategy paper for July board meeting.
3	Mar-15	10. Annual Equalities Report	Arrange a broad equalities/ Time to Change event	Louise Lyon	Sep-15	
4	Mar-15	11. HR Proposal on 360 Feedback	Proposal for 360 to be taken to leadership group	Susan Thomas	Jul-15	
2	Apr-15	6. CEO's Report	Add NEDs to 'Everyone' mailing list	Gervase Campbell	May-15	Relevant emails are being forwarded instead.
3	Apr-15	10.Quality Reports	Circulate further details of waiting time data	Justine McCarthy Woods	May-15	Completed - circulated 2nd June.
4	Apr-15	11. Draft Annual QR	Produce summary sheets for each service	Louise Lyon	Jul-15	

Outstanding Actions

Board of Directors : June 2015

Item : 6

Title : Chief Executive's Report

Summary:

This report provides a summary of my activities in the last month and key issues affecting the Trust.

For : Discussion

From : Chief Executive

Chief Executive's Report

1. Two year strategy

1.1 I have issued the consultation paper for the development of a medium term strategy for the Trust as agreed at the May Board meeting. A series of meetings have been arranged to discuss the strategy including two open staff meetings in July. A final strategy document will be brought to the Board of Directors meeting in July.

2. NHS Confederation Conference

2.1 I attended the annual NHS Confederation in Liverpool as did the Trust's Chair. There was a clear focus in many of the presentations and in discussion on the implications of finding the £22 billion of savings highlighted in the 5 Year Forward view.

2.2 An important session was held on the work of the Mental Health Taskforce, chaired by Paul Farmer, Chief Executive of Mind and commissioned by NHS England to help them set the strategy for mental health for the next 5 years.

2.3 The Taskforce has already received 20,000 responses from service users, carers and practitioners to a survey issued by Mind and Rethink Mental Illness seek input into the work of the Taskforce. 4 key themes have emerged from this:

- Prevention
- Access
- Integration
- Experience and attitudes

2.4 The Taskforce will be producing an in term report before the summer and a more detailed analysis in the early autumn in time to inform the Spending Review.

2.5 Rob Senior and I are attending a consultation event with Mental Health providers on Thursday 18th June on behalf of the Cavendish Square Group.

3. Thrive

3.1 We have been working colleagues in partner organisations to formalise arrangements around the development of the Thrive model for CAMHS.

3.2 As part of this we have agreed in principle to form a partnership with: the Anna Freud Centre, UCL Partners and the Dartmouth Center for Healthcare Delivery Science to promote the development of the Thrive model. We have two firm implementation sites: Camden and Islington with discussions in train in other areas.

3.3 On 3rd June I attended an introductory meeting with the new Minister for Care Services (whose brief includes mental health) Alastair Birt MP. He was able to confirm that CAMHS will continue to be an important priority for the new Government and that the additional investment announced in the March Budget will be secure going forward. He was keen to state his support for the work of the Children and Young People's Taskforce and I was able to brief him on the Thrive model.

4. Care Notes

4.1 After a significant amount of work with the supplier we have been able to confirm a revised go live date for the Care Notes system of 27th July.

4.2 We have agreed a plan with the supplier to ensure that we are ready for the new go live date and will be maintaining a senior focus on this to ensure the plan is delivered.

5. Monitor and TDA

5.1 An announcement was made on 11th June that the work of Monitor and the TDA would be coming together under the leadership of a single Chief Executive. David Bennett the current Chief Executive has written to announce to announce that he is intending to step down.

Paul Jenkins
Chief Executive
15th June 2015

Board of Directors : June 2015

Item : 7

Title : Finance and Performance Report

Summary:

After the two months a surplus of £570k is reported, £744k above the planned deficit of £174k. The main reason for the surplus is the number of vacancies across the organisation. We aim to have a small surplus by the end of the year.

Analysis by service line will be provided next month.

The cash balance at 31 May was £2,340k.

For : Information.

From : Simon Young, Director of Finance

1. External Assessments

1.1 Monitor

1.1.1 Monitor's assessment on Quarter 4 is awaited. It is expected that our Continuity of Service Risk Rating will remain at 4, and the rating for governance remain green.

1.1.2 The 2015/16 Plan was submitted to Monitor on 30 April. A revised 5 year Plan was not required. The Plan should lead to a Continuity of Service Risk Rating of 3.

2. Finance

2.1 Income and Expenditure 2014/15

2.1.1 After May the trust is reporting a surplus of £570k before restructuring costs, £744k above budget. Income is £37k below budget, and expenditure £768k below budget.

2.1.2 The income shortfall for May of £15k is mainly due to Consultancy income but this is expected to recover over the course of the year.

2.1.3 Consultancy is £47k below budget, £33k of which is due to TC.

2.1.3.1 Clinical Income was £46k above budget which was mainly due to GIDU NPAs. All the main income sources and their variances are discussed in sections 3, 4 and 5.

2.1.4 The favourable movement of £380k on the expenditure budget was due mainly to the Family Nurse Partnership (FNP) which now has a cumulative under spend of £156k due to vacancies and lower than expected non pay costs. GIDU are under spent £75k and Education and Training by £80k both due to vacancies. Within Complex Needs City & Hackney is also £44k under spent due to vacancies. The remainder of the under spend was mostly vacancies spread across the organisation.

2.1.5 The key financial priorities remain to achieve income budgets; and to identify and implement the future savings required through service redesign.

2.2 Cash Flow

2.2.1 The actual cash balance at 31 May was £2,340k this is a decrease of £1,373k in in month and is £2,258 below Plan. The balance was below Plan mainly due to the delay in raising the first two months clinical contract invoices as the contract amounts were not finalised. This has since been rectified. However, we have received payment for the majority of the out-standing GIDU over performance from 2014/15.

		Cash Flow year-to-date		
		Actual	Plan	Variance
		£000	£000	£000
Opening cash balance		**2,761**	2,761	0
Operational income received				
	NHS (excl HEE)	**3,512**	4,415	(903)
	General debtors (incl LAs)	**1,245**	2,065	(820)
	HEE for Training	**2,589**	2,599	(10)
	Students and sponsors	**443**	475	(32)
	Other	**0**	0	0
		7,789	9,554	(1,765)
Operational expenditure payments				
	Salaries (net)	**(2,957)**	(3,044)	87
	Tax, NI and Pension	**(2,194)**	(2,201)	7
	Suppliers	**(2,238)**	(1,910)	(328)
		(7,389)	(7,155)	(234)
Capital Expenditure		**(823)**	(565)	(258)
Interest Income		**1**	1	0
Payments from provisions		**0**	0	0
PDC Dividend Payments		**0**	0	0
Closing cash balance		**2,339**	4,596	(2,258)

3. Training

3.1 Income

3.1.1 Training income is £26k below budget in total after two months. Details are in the table below.

3.1.2 FNP income is currently being reported as £25k below budget but is expected to be on target by the end of the year.

3.1.3 DET is £26k below budget at the end of May due to postponed activity on CPPD which is due to take place before the end of August 2015.

3.1.4 The under spend on Junior medical staff is offset by a favourable variance on the expenditure budget.

3.2 Expenditure

3.2.1 There a number of vacancies across Training and these are expected to be filled over the course of the year.

LDA income (lines 4-7 appendix B)	YTD Budget £'000	YTD Actual £'000	YTD Variance £'000	Forecast £'000
NHS London Training Contract	1,209	1,209	0	0
Child Psychotherapy Trainees	358	366	8	0
Junior Medical Staff	154	121	-33	0
Postgraduate Medical and Dental (budget incl. study leave)	14	14	0	0
Sub Total	**1,736**	**1,710**	**-26**	**0**
Fees and academic income (lines 8-11 Appendix B)				
DET	68	42	-26	0
CAMHS	542	571	29	0
FNP	596	571	-25	0
SAAMHS	247	271	24	0
TC	39	36	-3	0
Sub Total	**1,491**	**1,491**	**-1**	**0**
Grand Total	**3,227**	**3,201**	**-26**	**0**

4. Patient Services

4.1 Activity and Income

4.1.1 Total contracted income for the year is expected to be in line with budget, subject to meeting a significant part of our CQUIN targets agreed with commissioners; achievement of these is reviewed on a quarterly basis. The majority of contracts are now block rather than cost and volume. Our commissioners have agreed to review this if there are material activity variances.

4.1.2 Variances in other elements of clinical income, both positive and negative, are shown in the table below. However, the forecast for the year is currently in line with budget in most cases, not in line with the extrapolated figures shown as "variance based on year-to-date."

4.1.3 The income budget for named patient agreements (NPAs) was reduced this year from £131k to £118k. After May actual income is £16k above budget.

4.1.5 Day Unit Income target was increased by £172k in 2015/16 and is on target after May.

	Budget	Actual	Variance	Full year		Comments
	£000	£000	%	Variance based on y-t-d	Predicted variance	
Contracts - base values	2,523	2,581	2.3%	346	0	Contracts are block for 2015/16
NPAs	25	41	67.3%	100	0	Over performed on GIDU
Projects and other	202	177		–	0	Income matched to costs, so variance is largely offset.
Day Unit	136	136	0.0%	0	0	
FDAC	536	532	-0.6%	-19	0	
Total	3,422	3,468		427	0	

5. Consultancy

5.1 TC are on budget target after two months. This consists of expenditure £36k underspent, TC Training Fees £3k below budget and consultancy £33k below budget. TC are currently reviewing and revising their forecast income and expenditure for the rest of the year.

5.2 Departmental consultancy is £14k below budget after May; £11k of the shortfall is within SAMHS.

Carl Doherty
Deputy Director of Finance
16 June 2015

THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST **APPENDIX A**

INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2015-16

		May-15			CUMULATIVE			FULL YEAR 2015-16	
		BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	BUDGET £000'S	ACTUAL £000'S	VARIANCE £000'S	REVISED BUDGET £000	OPENING BUDGET £000
INCOME									
1	CLINICAL	1,714	1,756	42	3,422	3,468	46	19,971	19,416
2	TRAINING	1,613	1,631	17	3,227	3,201	(26)	20,385	20,783
3	CONSULTANCY	115	50	(65)	228	181	(47)	1,369	1,640
4	RESEARCH	7	1	(6)	14	1	(13)	83	123
5	OTHER	4	1	(3)	58	61	3	418	819
TOTAL INCOME		**3,454**	**3,439**	**(15)**	**6,950**	**6,912**	**(37)**	**42,226**	**42,781**
OPERATING EXPENDITURE (EXCL. DEPRECIATION)									
6	CLINICAL DIRECTORATES	1,640	1,500	140	3,243	3,018	225	18,687	18,891
7	OTHER TRAINING COSTS	1,123	924	198	2,242	1,820	421	13,702	14,337
8	OTHER CONSULTANCY COSTS	63	31	32	127	91	36	765	787
9	CENTRAL FUNCTIONS	633	621	12	1,287	1,243	44	7,624	7,535
10	TOTAL RESERVES	(4)	0	(4)	26	0	26	208	(9)
TOTAL EXPENDITURE		**3,455**	**3,076**	**379**	**6,925**	**6,172**	**753**	**40,985**	**41,539**
EBITDA		**(1)**	**363**	**364**	**25**	**740**	**715**	**1,241**	**1,241**
	ADD:-								
11	BANK INTEREST RECEIVED	0	1	(0)	1	2	(1)	5	5
	LESS:-								
12	DEPRECIATION & AMORTISATION	64	62	2	129	113	16	775	775
13	FINANCE COSTS	0	0	0	0	0	0	0	0
14	DIVIDEND	35	34	1	70	59	11	421	421
SURPLUS BEFORE RESTRUCTURING COSTS		**(100)**	**267**	**366**	**(174)**	**570**	**744**	**50**	**50**
15	RESTRUCTURING COSTS	0	0	(0)	0	0	0	0	0
SURPLUS/(DEFICIT) AFTER RESTRUCTURING		**(100)**	**267**	**366**	**(174)**	**570**	**744**	**50**	**50**
EBITDA AS % OF INCOME		0.0%	10.6%		0.4%	10.7%		2.9%	2.9%

THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST — **APPENDIX B**

INCOME AND EXPENDITURE REPORT FOR THE FINANCIAL YEAR 2015-16

	All figures £000	May-15			CUMULATIVE					
		BUDGET	ACTUAL	VARIANCE	BUDGET	ACTUAL	VARIANCE	REVISED BUDGET	OPENING BUDGET	FORECAST
	INCOME									
1	CENTRAL CLINICAL INCOME	608	645	37	1,215	1,252	37	7,289	7,035	7,289
2	CAMHS CLINICAL INCOME	561	550	(11)	1,155	1,143	(12)	6,524	6,868	6,524
3	SAAMHS CLINICAL INCOME	312	286	(27)	587	568	(20)	3,368	2,865	3,368
4	GENDER IDENTITY	233	276	43	465	506	41	2,791	2,648	2,791
5	NHS LONDON TRAINING CONTRACT	604	604	0	1,209	1,209	0	7,254	7,254	7,254
6	CHILD PSYCHOTHERAPY TRAINEES	179	184	5	358	366	8	2,148	2,148	2,148
7	JUNIOR MEDICAL STAFF	79	56	(23)	154	121	(33)	927	900	927
8	POSTGRADUATE MED & DENT'L EDUC	5	4	(1)	14	14	(0)	84	111	84
9	DET TRAINING FEES & ACADEMIC INCOME	34	17	(17)	68	42	(26)	976	1,373	976
10	FAMILY NURSE PARTNERSHIP	298	299	1	596	571	(25)	3,574	3,574	3,574
12	CAMHS TRAINING FEES & ACADEMIC INCOME	271	299	28	542	571	29	3,392	3,392	3,392
13	SAAMHS TRAINING FEES & ACADEMIC INCOME	123	152	29	247	271	24	1,758	1,758	1,758
14	TC TRAINING FEES & ACADEMIC INCOME	20	16	(4)	39	36	(3)	272	272	272
15	TC INCOME	76	33	(43)	152	119	(33)	913	925	913
16	CONSULTANCY INCOME CAMHS	8	(0)	(8)	13	10	(3)	77	91	77
17	CONSULTANCY INCOME SAAMHS	31	17	(14)	63	52	(11)	379	624	379
18	R&D	7	1	(6)	14	1	(13)	83	123	83
19	OTHER INCOME	4	1	(3)	58	61	3	418	819	418
	TOTAL INCOME	**3,454**	**3,439**	**(15)**	**6,950**	**6,912**	**(37)**	**42,226**	**42,781**	**42,226**
	EXPENDITURE									
20	COMPLEX NEEDS	270	210	60	498	428	70	2,804	2,662	2,804
21	PORTMAN CLINIC	125	94	31	249	207	42	1,493	1,421	1,493
22	GENDER IDENTITY	184	135	49	368	293	75	2,211	2,079	2,211
23	DEV PSYCHOTHERAPY UNIT	12	7	5	25	20	5	106	106	106
24	NON CAMDEN CAMHS	611	602	9	1,220	1,174	46	6,898	7,222	6,898
25	CAMDEN CAMHS	370	377	(7)	755	769	(14)	4,428	4,639	4,428
26	CHILD & FAMILY GENERAL	67	74	(7)	127	126	1	747	762	747
27	FAMILY NURSE PARTNERSHIP	260	207	53	519	363	156	3,112	3,112	3,112
28	JUNIOR MEDICAL STAFF	83	65	18	166	135	31	993	993	993
29	NHS LONDON FUNDED CP TRAINEES	179	166	13	358	348	10	2,148	2,148	2,148
30	TAVISTOCK SESSIONAL CP TRAINEES	1	1	(0)	3	2	1	19	19	19
31	FLEXIBLE TRAINEE DOCTORS & PGMDE	26	11	14	52	29	22	309	309	309
32	EDUCATION & TRAINING	213	167	46	426	346	80	3,224	3,906	3,224
33	VISITING LECTURER FEES	138	115	23	277	239	38	1,332	1,332	1,332
34	CAMHS EDUCATION & TRAINING	134	129	4	263	248	14	1,548	1,503	1,548
35	SAAMHS EDUCATION & TRAINING	90	63	27	179	110	69	1,015	1,015	1,015
36	TC EDUCATION & TRAINING	0	0	0	0	0	0	0	0	0
37	TC	63	31	32	127	91	36	765	787	765
38	R&D	17	4	13	34	15	19	201	238	201
39	ESTATES DEPT	176	216	(40)	344	385	(41)	2,026	2,090	2,026
40	FINANCE, ICT & INFORMATICS	156	108	48	355	312	43	2,131	2,295	2,131
41	TRUST BOARD, CEO, DIRECTOR, GOVERN'S & PPI	86	104	(18)	173	174	(1)	1,038	981	1,038
42	COMMERCIAL DIRECTORATE	66	74	(8)	132	132	0	795	454	795
43	HUMAN RESOURCES	58	52	6	112	104	8	611	652	611
44	CLINICAL GOVERNANCE	62	51	11	125	109	16	751	824	751
45	CEA CONTRIBUTION	12	11	1	12	11	1	70	0	70
46	DEPRECIATION & AMORTISATION	64	62	2	129	113	16	775	775	775
47	VACANCY FACTOR	0	0	0	0	0	0	0	(134)	0
48	PRODUCTIVITY SAVINGS	0	0	0	0	0	0	0	(80)	0
49	INVESTMENT RESERVE	0	0	0	0	0	0	0	0	0
50	CENTRAL RESERVES	(4)	0	(4)	26	0	26	208	205	208
	TOTAL EXPENDITURE	**3,519**	**3,139**	**380**	**7,054**	**6,286**	**768**	**41,760**	**42,314**	**41,760**
	OPERATING SURPLUS/(DEFICIT)	**(65)**	**301**	**366**	**(105)**	**627**	**731**	**466**	**466**	**466**
51	INTEREST RECEIVABLE	0	1	0	1	2	1	5	5	5
52	DIVIDEND ON PDC	(35)	(34)	1	(70)	(59)	11	(421)	(421)	(421)
	SURPLUS/(DEFICIT)	**(100)**	**267**	**367**	**(174)**	**570**	**744**	**50**	**50**	**50**
53	RESTRUCTURING COSTS	0	0	(0)	0	0	0	0	0	0
	SURPLUS/(DEFICIT) AFTER RESTRUCTURING	**(100)**	**267**	**367**	**(174)**	**570**	**744**	**50**	**50**	**50**

APPENDIX D

2015/16 Plan	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Opening cash balance	2,761	5,420	4,596	4,150	4,621	3,087	1,788	3,708	2,870	1,794	3,726	3,143	2,761
Operational income received													
NHS (excl HEE)	2,500	1,915	2,423	1,588	1,505	1,475	1,466	1,504	1,475	1,466	1,504	1,476	20,297
General debtors (incl LAs)	1,171	894	500	657	785	585	770	849	923	820	1,186	1,023	10,163
HEE for Training	2,457	142	79	2,457	143	79	2,457	142	79	2,457	143	79	10,717
Students and sponsors	325	150	150	100	0	200	800	250	100	750	100	100	3,025
Other	0	0	0	0	0	0	0	0	0	0	0	0	0
	6,453	3,101	3,152	4,802	2,433	2,339	5,493	2,745	2,577	5,493	2,933	2,678	44,202
Operational expenditure payments													
Salaries (net)	(1,622)	(1,422)	(1,433)	(1,833)	(1,633)	(1,454)	(1,485)	(1,471)	(1,468)	(1,462)	(1,462)	(1,462)	(18,207)
Tax, NI and Pension	(1,100)	(1,101)	(1,101)	(1,109)	(1,110)	(1,110)	(1,124)	(1,147)	(1,137)	(1,135)	(1,131)	(1,130)	(13,435)
Suppliers	(1,072)	(838)	(865)	(1,090)	(865)	(565)	(865)	(865)	(865)	(865)	(865)	(865)	(10,481)
	(3,794)	(3,361)	(3,399)	(4,032)	(3,608)	(3,129)	(3,474)	(3,483)	(3,470)	(3,462)	(3,458)	(3,457)	(42,123)
Capital Expenditure	0	(565)	(200)	(300)	(360)	(300)	(100)	(100)	(185)	(100)	(60)	(100)	(2,370)
Loan	0	0	0	0	0	0	0	0	0	0	0	0	0
Interest Income	0	1	0	1	0	1	0	0	1	0	1	0	5
Payments from provisions	0	0	0	0	0	0	0	0	0	0	0	0	0
PDC Dividend Payments	0	0	0	0	0	(211)	0	0	0	0	0	(210)	(421)
Closing cash balance	5,420	4,596	4,150	4,621	3,087	1,788	3,708	2,870	1,794	3,726	3,143	2,055	2,055

2015/16 Actual/ Forecast	**April**	**May**	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
	£000	**£000**	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Opening cash balance	**2,761**	**3,792**	2,339	2,592	4,763	3,289	2,090	4,010	3,173	2,097	4,028	3,445	2,761
Operational income received													
NHS (excl HEE)	**1,274**	**2,238**	2,823	2,588	1,505	1,475	1,466	1,504	1,475	1,466	1,504	1,476	20,794
General debtors (incl LAs)	**1,120**	**125**	800	1,057	785	585	770	849	923	820	1,186	1,023	10,043
HEE for Training	**2,471**	**118**	79	2,457	143	79	2,457	142	79	2,457	143	79	10,707
Students and sponsors	**356**	**87**	150	100	0	200	800	250	100	750	100	100	2,993
Other	**0**	**0**	0	0	0	0	0	0	0	0	0	0	0
	5,221	**2,568**	3,852	6,202	2,433	2,339	5,493	2,745	2,577	5,493	2,933	2,678	44,537
Operational expenditure payments													
Salaries (net)	**(1,533)**	**(1,425)**	(1,433)	(1,833)	(1,633)	(1,454)	(1,485)	(1,471)	(1,468)	(1,462)	(1,462)	(1,462)	(18,120)
Tax, NI and Pension	**(1,068)**	**(1,127)**	(1,101)	(1,109)	(1,110)	(1,110)	(1,124)	(1,147)	(1,137)	(1,135)	(1,131)	(1,130)	(13,428)
Suppliers	**(1,326)**	**(912)**	(865)	(890)	(865)	(565)	(865)	(865)	(865)	(865)	(865)	(865)	(10,609)
	(3,926)	**(3,463)**	(3,399)	(3,832)	(3,608)	(3,129)	(3,474)	(3,483)	(3,470)	(3,462)	(3,458)	(3,457)	(42,157)
Capital Expenditure	**(264)**	**(559)**	(200)	(200)	(300)	(200)	(100)	(100)	(185)	(100)	(60)	(100)	(2,368)
Loan	**0**	**0**	0	0	0	0	0	0	0	0	0	0	0
Interest Income	0	1	0	1	0	1	0	0	1	0	1	0	5
Payments from provisions	**0**	**0**	0	0	0	0	0	0	0	0	0	0	0
PDC Dividend Payments	**0**	**0**	0	0	0	(211)	0	0	0	0	0	(210)	(421)
Closing cash balance	**3,792**	**2,339**	2,592	4,763	3,289	2,090	4,010	3,173	2,097	4,028	3,445	2,357	2,357

Board of Directors : June 2015

Item : 8

Title: Training & Education Board June 2015 report

Purpose:

To report on issues considered and decisions taken by the Training & Education Programme Management Board at its meeting of 1st June 2015.

This report focuses on the following areas:

- Quality
- Risk
- Finance

For : Noting

From : Brian Rock, Director of Education & Training / Dean of Postgraduate Studies

Training & Education Board Report

June 2015

1 Introduction

1.1 The Training & Education Programme Management Board (TEPMB) held its ninth meeting on 1st June 2015.

2 National Contract and CPPD Contract

2.1 Brian Rock presented an update on this item.

2.2 The programme board was informed that the value for the national contract has been confirmed at the same value and that the work plan for the contract was well received.

2.3 Levels of CPPD commissioning are as they were two years ago at present which is an increase on the figures from last year.

2.4 Will Bannister is leading on contact with CCG's and CSU's about the Trust's offer. This is funded separately to the main CPPD contract.

3 Education and Training Restructure

3.1 Simon Carrington attended for this item and presented his proposal for the restructure of committees within Education and Training to the programme board.

3.2 The board had a positive discussion related to the changes proposed with an emphasis on maintaining links with clinical directorates and clinical practice in relation to course development.

3.3 It was suggested that the document needed to be clearer in relation to who was responsible for meeting targets and in regards to processes relating to new course development.

3.4 It was agreed that changes to the report did not need to be returned to the board for approval but can be circulated once complete.

4 Programme Office Update

4.1 Brian Rock informed the programme board that with Paul Jenkins approval he has recruited a Programme Director to assist with the transformation portfolio in the department.

4.2 Resource has also been identified to recruit a project manager to assist him.

4.3 The group discussed the difficulties of placing someone in such a role on an interim basis and it was agreed that Brian Rock would provide a further update at the next programme board.

5 ICT Procurement

5.1 Will Bannister presented a report on this item.

5.2 He discussed the increased level of supplier engagement that had taken place and informed the programme board that two bids had now been received.

5.3 The programme board had a discussion about the number of bids received and Brian Rock highlighted how much work had gone into engaging with suppliers and the learning taken from this.

6 Marketing and Targets

6.1 Laure Thomas, Karen Tanner and Elisa Reyes-Simpson presented a report on this item.

6.2 Laure Thomas gave an update on the work that has been undertaken with regard to marketing in particular the meeting of the Trust's web reference group, adverts being placed in The Guardian for the D24 and market research that was now being undertaken to assist in student recruitment.

6.3 The programme board discussed recruitment figures and the difficulties that had been found in assessing these due to a lack of reliable data for previous years making it difficult to ascertain at what level applications were at this point last year.

6.4 Karen Tanner brought to the programme boards attention concerns amongst course tutors in relation to targets, incomplete applications and lack of advertising this year.

6.5 It was agreed that a bi-weekly report on this item would be circulated to board members.

7 University of East London and University of Essex Update

7.1 Brian Rock presented an update on this item.

7.2 Discussions with University of Essex regarding course validation are progressing well and they will be issuing a letter of intent stating that all

courses for 2015/16 can be advertised as Essex courses (with the exception of the M23 which will remain with the University of East London).

7.3 Joint meetings with the Trust, the University of Essex and associate centres are also underway and will be complete before the end of July.

7.4 All three parties met on 15th May to discuss the transfer of students from the University of East London to the University of Essex. An action plan was agreed and has since been circulated and largely approved.

7.5 A further communication will be sent to students in the coming weeks relating to the transfer.

8 Regional Strategy

8.1 Brian Rock presented an update on this item.

8.2 It has been agreed that Karen Tanner will now manage the regional strategy.

8.3 A number of meetings have been arranged to develop the Trusts regional strategy across the country.

8.4 The programme board had a productive discussion as to how the strategy should develop and agreed that there should be a combination of managing existing relationships while at the same time developing new ones.

9 The Trust's Two Year Strategy

9.1 Paul Jenkins informed the programme board that the Trust's two year strategy had been taken to the Board of Directors at its May meeting.

9.2 He suggested that this be brought to the July programme board for further discussion.

10 QAA Action Plan

10.1 The QAA Action Plan was brought to the programme board for approval which was given.

10.2 Brian Rock asked that areas for improvement be fully specified which Paul Jenkins agreed to.

Brian Rock
Director of Education & Training / Dean of Postgraduate Studies

Board of Directors : June 2015

Item : 9

Title : Service Line Report: Gender Identity Development Service (GIDS)

Purpose:

This paper is written to provide the Board of Directors with assurance of achievements and progress towards meeting Service and Trust-wide objectives by the Gender Identity Development Service

This report has been reviewed by the following Committees:

- Management Committee, 11th June 2015

This report focuses on the following areas:

- Quality
- Patient / User Experience
- Risk
- Finance
- Communications

For : Discussion

From : Dr Polly Carmichael, Director GIDS

Service Line Report
Gender Identity Development Service

Executive Summary

1. Introduction

1.1 The GIDS is a highly specialist nationally designated interdisciplinary service unique to the NHS. We see children and young people up to the age of 18 years and their families who are experiencing difficulties in the development of their gender identity. We also offer counselling to children of parents with transsexualism or other gender identity problems.

The Service operates from two main bases, London and Leeds, with regular outreach clinics held in Exeter. We have links with CAMHS in Bristol, Bath and Barnstaple and on occasion use their rooms for outreach clinics. We are looking to develop a similar model of service delivery in South Wales.

The Service currently employs the following staff:

<u>London</u>
Director – 0.6 WTE
Service Manager – 1.0 WTE
Child and Adolescent Psychiatrist – 0.5 WTE
Clinical Psychologists – 8.4 WTE
Social Workers – 1.6 WTE
Child and Adolescent Psychotherapists – 2.2 WTE
Administration staff – 4.0 WTE
Research Psychologist – Vacant (0.8 WTE)
Research Assistants – 2.0 WTE

<u>Leeds</u>
Clinical Psychologists – 2.5 WTE
Family Therapists – 1.2 WTE
Administration staff – 1.0 WTE
Research Assistant – 1.0 WTE

Please see appendix 1 for a breakdown of current staff by banding.

The service is funded via a National Contract with NHS England covering patients from England and Scotland. Patients from other areas of the UK are covered via Named Patient Agreements (namely Wales). The service receives a small number of referrals from European Countries (e.g. Ireland and Malta). The service offers regular consultations in Belfast and supported the development of a service there based on the GIDS model and protocol. A similar project is underway in Dublin.

Areas of Risk and/or Concern

1.2 The Service is continuing to see a large increase in the number of referrals received, by an average of 50% per annum since April 2009. Clinicians in the service are under considerable pressure to meet the 18 week wait time for first appointments. With the increase in referrals, the number of complex cases has increased; for example young people presenting with significant associated difficulties, features of ASD and challenging social circumstances. Self-harm is not unusual in adolescent service users and local CAMHS can be difficult to engage to manage this risk. Clinicians carry large caseloads to meet the demands of high referral rates. Young people most often remain with the service for a number of years. On average, young people are seen around 5 times a year.

1.3 This financial year (2015-2016) we moved to a Block Contract. This has given the service a more generous starting point than in previous years, which will enable us to employ more staff nearer the start of the financial year. In previous years we have been on a Cost and Volume Contract and over-performance yielded increased funding which allowed the service to take on extra locum staff later in the financial year. This will not be possible this year and locum staff can only be funded through underspend accumulated via vacant posts. Depending on the number of referrals the block contract may have a positive impact on the timely throughput of referrals for this financial year.

1.4 The appropriate management of Gender Dysphoria in children and adolescents is contentious and debated in the absence of an adequate evidence base. A currently small number of families, usually associated with a long standing parents support/pressure group, have been vociferous about their frustration with our

protocol for physical intervention. Specifically, the time taken to complete a comprehensive assessment of Gender Dysphoria prior to referral for physical intervention is referred to as "a delay in treatment" and there is increasing pressure to offer cross sex hormones from the age of 14 years, rather than the current 16 years. Adult services continue to have long waiting lists, this creates problems for some older service users who are keen to move to adult services to pursue surgical interventions and places a strain on the GIDS resources, as until they are on a stable hormonal regimen it is not appropriate to discharge service users over 18 years old to their GP.

1.5 The GIDS commissions Adolescent Endocrine Liaison Clinics in London and Leeds. In Leeds the clinics are held at Leeds General Infirmary (LGI). The LGI have not been able to agree any increase in capacity until January 2016, which will create a waiting list for physical assessment and intervention which in turn will be problematic for service users.

2. Proposed Action Plan

2.1 We have been actively reviewing staff caseloads via management. In addition, an increase in the baseline contract value means we are able to recruit approximately 5.1 WTE of new permanent clinical staff.

2.2 We are in the process of reviewing our Intake process and considering implementing stricter acceptance criteria around the ongoing holding and management of risk by local CAMHS teams. However, this presents its own challenges as it is difficult to reject any referrals where gender dysphoria is present as this could delay timely physical treatment, if appropriate, and could exacerbate difficulties.

2.3 The GIDS initiated discussions with the adult gender CRG and a sub group of the adult Gender CRG was formed last year to develop a transition policy. It is likely that extra funding will be made available to adult services to address their long waiting lists and they will 'fast track' the assessment process for service users referred by the GIDS.

2.4 A task and finish group commissioned by NHS England has a review of the GIDS clinical specifications as part of their remit. The Director of the GIDS has met with the new lead commissioner for the service and plans are underway to complete this review in the next few months. The previous specifications were written in 2009 and require updating. Stakeholders and support groups will be involved in the process of updating the current clinical specifications.

Main Report

3. Overview of the Service

3.1 The Gender Identity Development Service (GIDS) is a national highly specialist service, commissioned by NHS England and is staffed by an interdisciplinary team. The team consists of a child and adolescent psychiatrist, clinical psychologists, social workers, family therapists and child and adolescent psychotherapists.

3.2 We see children and adolescents (up to the age of 18) and their families who are experiencing difficulties in the development of gender identity. Typically, these young people feel that their biological or assigned sex does not match their gender identity. Some may be boys who feel or believe they are girls and vice versa. The onset of puberty is commonly associated with an escalation of distress and an increased risk of self-harming behaviours.

3.3 The Service offers counselling to children with a transsexual parent. Assessment and advice are provided to the Courts at their request. Court reports usually result in referral to the GIDS which is covered by the national contract. In practice, this work has significantly reduced in the last 5 years.

3.4 Referrals to the service have increased year on year as follows:

- 2009/10 – 97 referrals
- 2010/11 – 139 referrals
- 2011/12 – 208 referrals
- 2012/13 – 314 referrals
- 2013/14 – 468 referrals
- 2014/15 – 697 referrals

- 2015/16 – thus far, over April and May, we received 198 referrals.

Please see appendix 2 for service referral data over the last 6 years in graph form, with breakdowns by age and natal sex.

3.5 The GIDS follows and contributes to international and national guidelines on the management of GID in children and adolescents. These include the Royal College of Psychiatrists Guidelines on the Management of GID (1998) and the Statement of Management of Children and Adolescents with GID issues by the British Society of Paediatric Endocrinology and Diabetes (BSPED, 2010).

3.6 The GIDS offers comprehensive and interdisciplinary assessment and treatment of children and adolescents with Gender Dysphoria (GD). The Service recognises that GD can be an extremely distressing condition, for those who present with it and their families/carers. We endeavour to help young people and their families manage the uncertainties inherent in the outcome of gender dysphoria and provide on-going support and opportunities for exploration of gender identity.

3.7 We require local CAMHS teams to remain involved in referred cases and regularly convene local network meetings at the young person's local CAMHS or school. Many of the young people we work with have significant associated difficulties and the meetings are used to discuss these, as well as the management of issues associated with gender identity development and agree roles and actions moving forward.

3.8 The GIDS team at the Tavistock (London and Leeds) work closely with Paediatric Endocrine colleagues at University College London Hospital (UCLH) and Leeds General Infirmary (LGI) who are commissioned by us through a Service Level Agreement to provide Endocrine Liaison clinics. Following a detailed assessment and a period of therapeutic work, a referral may be considered for a selected number of cases to the Paediatric Endocrinology Liaison Clinic.

3.9 We provide two types of endocrine liaison clinic: The Early Intervention Clinic is available for carefully selected young

adolescents in at least Tanner stage 2 of puberty and up to age 15; and Standard clinics for adolescents aged 15 – 18 years.

3.10 After a series of physical tests young people may be prescribed hormone blockers. This intervention is putatively completely reversible. The blockers produce a state of hormonal neutrality. The pausing of physical pubertal development aims to reduce distress associated with this and so facilitates reflection and further exploration of the young person's gender identity. Such interventions are considered as part of an overall treatment plan offered by the Gender Identity Development Service and other therapeutic treatment/consultation and psychological monitoring remain ongoing. When possible the GIDS clinicians attend the endocrinology liaison clinics with their patients but when not possible another GIDS clinician will be present. This is considered important as it represents the integration of the mind and body.

3.11 An analysis of referrals to the service over the last 3 years showed the following number of patients were subsequently referred onto the Paediatric Endocrinology Liaison Clinic:

- 2012/13 – 105 (33% of all referrals to the service)
- 2013/14 – 124 (26% of all referrals to the service)
- 2014/15 – 25 (4% of all referrals to the service)

The above data shows the percentage of young people referred to the Service within the year specified, who have subsequently been referred to the endocrine clinic. This explains why the percentage for 2014/15 is currently low.

3.12 The service protocol is regularly reviewed to identify innovative and cost effective ways of providing the service without compromising the quality of care. Examples of recent initiatives include family days, groups for young people and parents/carers and education days at UCLH to provide information about physical treatments.

4. Clinical Services and Activity Data

4.1 Last financial year, the Service was on a cost and volume contract with NHS England. The GIDS generated approximately £1m of additional income for activity above the baseline contract. Whilst

extra income was generated it was of limited value in service planning at the start of the financial year. This year we have moved to a block contract with a relatively generous starting point compared to previous years. This is positive in terms of service planning but the impact of this change in contracting will require ongoing evaluation.

4.2 The team has worked incredibly hard not to breach any waiting times (our commissioner led waiting time target is 18 weeks). There was one incident of a breach in recent months, and this was owing to an administrative error because of a duplicate referral that was received at the time we were transferring from RiO to CareNotes.

4.3 Our DNA rate in 2014/15 was 8%. We have consistently maintained a DNA rate of less than 10% over the last few years.

4.4 It is difficult to comment on dormant cases for GIDS because our patients are seen infrequently. Therefore there are many cases that may not have been seen in over 3 or 6 months, but appropriately so.

5. Financial Situation

5.1 This year we moved from a cost and volume to a block contract. As such the income has increased in line with over performance at month 6 last year. Our baseline income is currently approx. £2.7m.

5.2 The budget for 2015-16 has just been agreed. As such there will be underspend accumulating from unfilled posts. We plan to use this underspend to employ locum staff to manage the increases in referral numbers.

5.3 If referrals increase by more than 50% this year, we will require additional resource to manage demand which will need to be discussed with NHS England.

5.4 We have been able to make some cost savings in our budget this year by re-negotiating our Service Level Agreements (SLA) with UCLH and LGI. While the overall cost of the contracts has increased to meet demand, value for money is better. For example, in London, our SLA cost has risen from £80k to £112k (40% increase), but the

number of clinics procured has increased from 60 to 120 (i.e. 50% increase). In Leeds, we have reduced the SLA value from £44k to £35k, but maintain the same number of clinics per annum. This has been possible by auditing the tests and investigations used by the Endocrinologists and dropping tests that are no longer considered necessary.

6. Feedback and Complaints

6.1 Please see appendix 3 for ESQ data received by the GIDS in 2014-15.

6.2 Response rates are typically low across the Trust. We are working with staff at main reception to try and get more forms handed out with a view to people completing them in the waiting room before their appointment. If people leave the building with the forms, most often we don't get them back.

6.3 The number of complaints to the service is relatively low both in relation to the number of referrals to the service and the contentious nature of the timing of physical intervention. There have been three families with late presenting adolescents who have complained about the protocol and length of time on the blocker prior to cross sex hormones (1 year) and the risk of self-harm by the young person because of this.

6.4 Two families have escalated their complaints to NHS England under the whistleblowing policy. The main issue raised was the management of risk in the service. With the support of the Medical Director and Risk Advisor a workshop on risk was run for all clinical staff.

6.5 One mother of a young service user wrote an 'informal' complaint following a local meeting. This was the first meeting with the mother who disagreed with the evidence base discussed in the meeting and felt the clinicians were not sympathetic to her child's situation.

6.6 All complaints have been responded to by the Director of the Service in collaboration with the clinicians involved and the Trust's complaints management team.

7. Clinical Governance

7.1 Two workshops were run in February and April 2015 by Rob Senior and Jane Chapman. This followed two complaints to NHS England. Many of the cases referred to the GIDS have associated difficulties and in adolescent service users the risk of self-harm is increased. The workshops reviewed how risk is managed in the National Service and offered the opportunity to discuss some of the more complex issues the clinicians work with.

8. Education and Training

8.1 The GIDS holds regular CPD and Conference Events. The last conference in July 2014 celebrated the work and achievements of Dr Domenico Di Ceglie, the founder and former Director of the Service from 1989-2009.

8.2 There is a CPD event targeted at professionals working with young people experiencing gender dysphoria on 2nd July 2015.

9. Outcome Monitoring, Research and Audit

9.1 The GIDS uses several outcome measures to assess Gender Dysphoria and associated difficulties over time. Questionnaires are usually completed during the assessment stage and then repeated at regular intervals post assessment, usually at 6 months or one year, depending on the measure. For a full list of questionnaires used by the Service, please see appendix 4.

9.2 In 2010, two outcome measures were agreed with the then commissioners:

- Self-harming behaviours pre and post attendance at the GIDS
- Children's Global Assessment Scale (CGAS) measures every 6 months

Data is presented in appendix 5.

9.3 The GIDS is actively involved in Research and Audit. A list of current audit and research projects is listed in Appendix 6.

9.4 One important piece of research we have conducted is an evaluation of physical intervention in the early stage of puberty. This study monitored the outcomes of using the hypothalamic blocker in a carefully selected group of younger adolescents. Preliminary findings for the study are presented in appendix 7.

9.5 We regularly write for professional journals and books – publications in the last year are presented in appendix 8. Members of the team regularly attend and present at National and International Conferences. A number of papers were selected for presentation at the 2014 World Professional Association for Transgender Health (WPATH) Biannual Conference and the new established European equivalent (EPATH) in March 2015.

9.6 We hold regular monthly research meetings where all members of the team can contribute to audit and research planning.

9.7 The GIDS are committed to collaborating with European colleagues to increase the evidence base around gender dysphoria and appropriate treatment. For example, there is an audit of general psychological wellbeing in progress in collaboration with the Dutch Gender Clinic.

9.8 We regularly provide opportunities for research for post-graduate students undertaking further professional training(s).

10. Staffing and HR issues

10.1 The current establishment of the GIDS is described in the Executive Summary (see 1.1). With the increased income this year, we plan to recruit 4.0 WTE of new clinical staff and increase existing staff sessions by 1.1 WTE. In addition, we plan to use underspend from vacant posts to fund locum posts to help meet the demands of high referral rates.

10.2 The number of staff required and structure of the team is carefully planned to take into account the increase in referrals year on year and the level of complexity of referrals to the service. It is essential to maintain an adequate number of senior staff, both to appropriately manage complexity and support junior staff. We have

developed posts at different grades to support a career pathway for staff that recognises their expertise in this highly specialist work. Due to the way NHS England budgets are agreed and the time it takes to achieve this, we are always down on the staffing levels required at the beginning of each financial year, as it takes a number of months to fill new posts.

10.3 It has taken some time to find appropriate staff for the Leeds base but there is now an excellent team in place. However, the past yeae has been very difficult for the team as their base has been far too small to accommodate more staff. It took a long time to find and agree appropriate new premises. In the meantime the Leeds Team do not have enough clinical space and are struggling to complete work as they cannot access computers (CareNotes) throughout the day when space is needed clinically. Connectivity to the Leeds team remains a major issue and we are regularly not able to connect with Leeds for our weekly team meeting, which we hold via video conference.

10.4 The GIDS team, clinical and administrative, are committed and enthusiastic, but all staff are under huge pressure to manage the number of referrals to the service.

10.5 Please see appendix 9 for brief accounts from some newer members of staff on their experience of the team.

10.6 We hold regular supervision and discussion groups for clinical staff. Where possible we try and video link with the Leeds team to allow their participation in these meetings. Current groups we run include:

- Psychoanalytic Discussion Group (with Louise Lyon, previously Alessandra Lemma)
- Complex Cases Discussion Group
- Post Modern Study Group

10.7 Regular one to one supervision is provided via line managers and staff are encouraged to attend discipline meetings.

11. Communications

11.1 Gender Dysphoria has received a huge amount of media interest over the past year. The service is committed to raising awareness and providing a balanced view of the complex issues associated with gender dysphoria in children and adolescents. This is increasingly taking up a lot of time. The Tavistock Communications team, especially Emma Heath and Matt Cooper have been hugely helpful and supportive with all media work we have been involved with.

11.2 The service is committed to working with user groups and support groups. Last year the service started a stakeholders group which meets three times a year. The group has been supported by Anthony Newell in PPI and has received input from the Communications team and HR. A member of the group has since formed part of an interview panel for a GIDS appointment.

11.3 The service is currently engaged in developing a website. This is an exciting and important project which will benefit service users and referrers and help the service to provide realistic expectations and accurate information about the service. Stakeholders will be involved in this process.

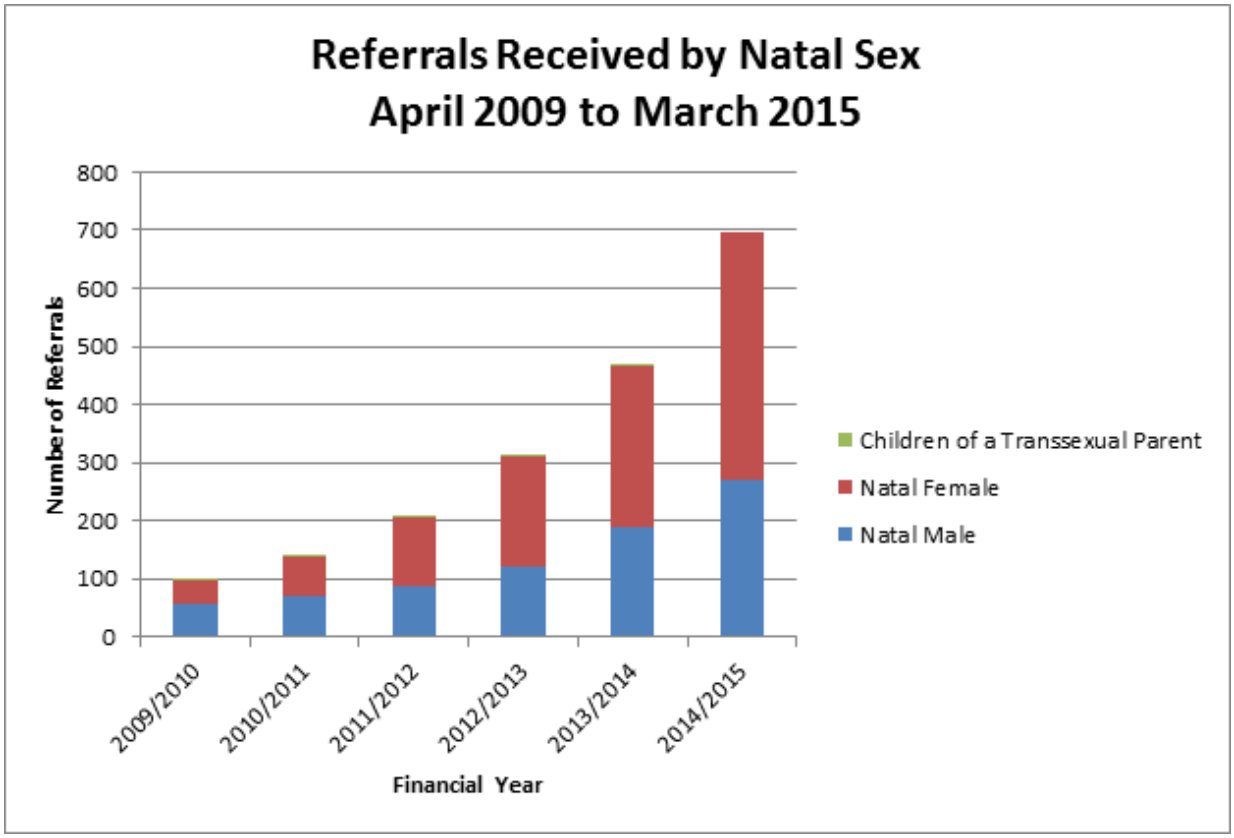
Appendix 1
GIDS Staff List by Band

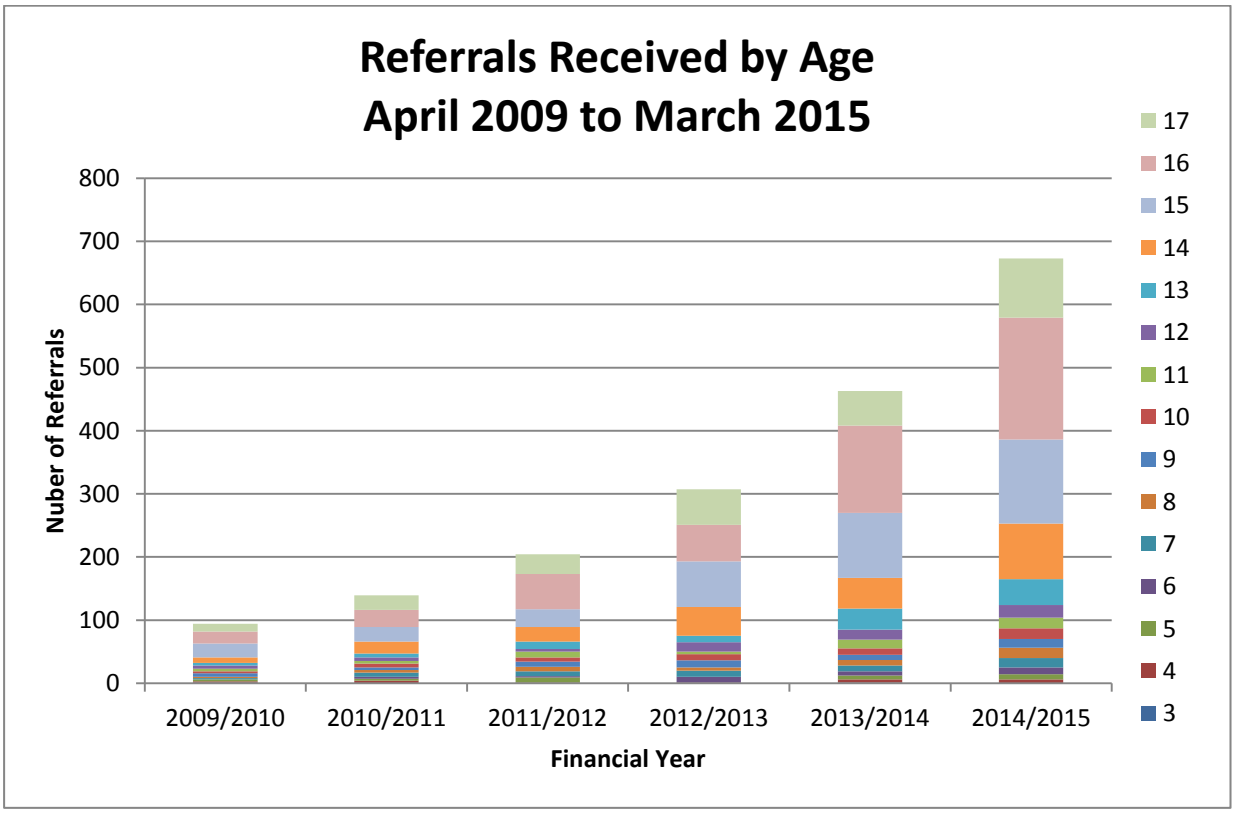
Staff Name	Main Base	Job Title	Sessions
Band 8D			
Polly Carmichael*	London	GIDS Director, Consultant Clinical Psychologist	0.6 WTE
Medical Consultant			
Vicky Holt*	London	Consultant Child and Adolescent Psychiatrist	0.5 WTE
Band 8C			
Bernadette Wren*	London	Consultant Clinical Psychologist	0.4 WTE
Sarah Davidson*	London	Consultant Clinical Psychologist	0.5 WTE
Sally Phillott*	Leeds	Leeds Clinical Lead, Consultant Clinical Psychologist	0.6 WTE
Band 8B			
Garry Richardson*	London	Senior (Principal) Social Worker	1.0 WTE
Charlie Beaumont*	London	Senior (Principal) Child and Adolescent Psychotherapist	0.6 WTE
Robert Whittaker	Leeds	Principal Clinical Psychologist	0.3 WTE
Anna Hutchinson	London	Principal Clinical Psychologist	0.6 WTE
Band 8A			
Helen Dalton	London	Highly Specialist Social Worker	0.6 WTE
Sarah Favier	Leeds	Highly Specialist Family Therapist	0.6 WTE
Ashley Miller	London	Highly Specialist Clinical Psychologist	0.8 WTE
Claudia Zitz	London / Leeds	Highly Specialist Clinical Psychologist with cross site responsibilities	0.8 WTE
Laura Charlton	Leeds	Highly Specialist Clinical Psychologist	0.6 WTE
James Barclay	Leeds	Highly Specialist Family Therapist	0.6 WTE
Melissa Midgen	London	Highly Specialist Child and Adolescent Psychotherapist	0.6 WTE
Band 7			
Keyur Joshi*	London	Service Manager	1.0 WTE
[Elin Skagerberg] – Vacant	London	Research Psychologist	0.8 WTE
Marina Bonfatto	London	Child and Adolescent Psychotherapist	1.0 WTE
Trilby Langton	London / Bristol	Clinical Psychologist	1.0 WTE
Nicolien Le Roux	London	Clinical Psychologist	0.6 WTE
Natasha Prescott	London	Clinical Psychologist	1.0 WTE
Hannah Waters	London	Locum Clinical Psychologist	1.0 WTE
Matt Bristow	London / Leeds	Locum Clinical Psychologist	1.0 WTE

Michelle Daniels	London	Locum Clinical Psychologist	0.5 WTE
Heather Wood	Leeds	Locum Clinical Psychologist	1.0 WTE
Band 5			
Hali Has	London	PA to GIDS Director	1.0 WTE
Oksana Kravchuk	London	Intake and Discharge Administrator	1.0 WTE
Band 4			
Michael Dunsford	London	Research Assistant / Assistant Psychologist	1.0 WTE
Nastasja De Graaf	London	Research Assistant / Assistant Psychologist	1.0 WTE
Amelia Taylor	Leeds	Research Assistant / Assistant Psychologist (Agency)	1.0 WTE
Naomi Hamm	London	Service Administrator	1.0 WTE
Richard Parkin	London	Service Administrator	1.0 WTE
Sophia Shepherd	Leeds	Receptionist and Administrator	1.0 WTE

***** Member of the GIDS Executive Team

Appendix 2
Referral Graphs





Appendix 3
GIDS ESQ Summary 2014-15

I feel that the people who have seen my child/me listened to me

	Frequency	Percentage
certainly true	62	91.18%
partly true	6	8.82%
not true	0	0.00%
not known	0	0.00%
Total	68	100.00%

It was easy to talk to the people who have seen my child/who saw me

	Frequency	Percentage
certainly true	52	76.47%
partly true	16	23.53%
not true	0	0.00%
not known	0	0.00%
Total	68	100.00%

I was treated well by the people who have seen my child/who saw me

	Frequency	Percentage
certainly true	64	94.12%
partly true	4	5.88%
not true	0	0.00%
not known	0	0.00%
Total	68	100.00%

My views and worries were taken seriously

	Frequency	Percentage
certainly true	60	88.24%
partly true	7	10.29%
not true	1	1.47%
not known	0	0.00%
Total	68	100.00%

I feel the people here know how to help with the problem I came for

	Frequency	Percentage
certainly true	53	77.94%
partly true	13	19.12%
not true	1	1.47%
not known	1	1.47%
Total	68	100.00%

I have been given enough explanation about the help available here

	Frequency	Percentage
certainly true	51	75.00%
partly true	15	22.06%
not true	1	1.47%
don't know	1	1.47%
Total	68	100.00%

I feel that the people who have seen my child/me are working together to help with the problems

	Frequency	Percentage
certainly true	54	79.41%
partly true	12	17.65%
not true	0	0.00%
don't know	1	1.47%
Total	68	100.00%

The facilities here are comfortable

	Frequency	Percentage
certainly true	50	73.53%
partly true	18	26.47%
not true	0	0.00%
don't know	0	0.00%
Total	68	100.00%

The appointments are usually at a convenient time

	Frequency	Percentage
certainly true	30	44.12%
partly true	26	38.24%
not true	12	17.65%
don't know	0	0.00%
Total	68	100.00%

It is quite easy to get to the place where the appointments are

	Frequency	Percentage
certainly true	23	33.82%
partly true	31	45.59%
not true	14	20.59%
don't know	0	0.00%
Total	68	100.00%

If a friend needed similar help I would that he or she come here

	Frequency	Percentage
certainly true	60	88.24%
partly true	7	10.29%
not true	0	0.00%
don't know	1	1.47%
Total	68	100.00%

Overall, the help I have received here is good

	Frequency	Percentage
certainly true	61	91.04%
partly true	6	8.96%
not true	0	0.00%
don't know	0	0.00%
Total	67	100.00%

Appendix 4
List of Outcome Measures / Questionnaires used by GIDS

First Assessment

Measure	Person	Ages
Youth Self Report	Self	12 to 18
Gender Identity Interview (Natal M)	Self	12 to 18
Gender Identity Interview (Natal F)	Self	12 to 18
Utrecht Gender Dysphoria Scale (Natal M)	Self	12 to 18
Utrecht Gender Dysphoria Scale (Natal F)	Self	12 to 18
Body Image Scale (Natal M)	Self	12 to 18
Body Image Scale (Natal F)	Self	12 to 18
Recalled Childhood Gender Identity Scale (Natal M)	Self	12 to 18
Recalled Childhood Gender Identity Scale (Natal F)	Self	12 to 18
Child Behaviour Checklist	Parent	All Ages
Social Responsiveness Scale 2	Parent	All Ages
GIDS Questionnaire for Children (Natal M)	Parent	Under 12
GIDS Questionnaire for Children (Natal F)	Parent	under 12
Teachers Report Form	Teacher	All Ages
Associated Difficulties	Clinician	All Ages
C-GAS	Clinician	All Ages
Self Harming Thoughts and Behaviours	Clinician	All Ages
Dimensional DSM Criteria	Clinician	12 to 18
Gender Identity Biographic Data	Clinician	12 to 18

Post-Assessment

CHI-ESQ Child (9 - 11)	Self	9 to 11
CHI-ESQ Young Person (12 - 18)	Self	12 to 18
CHI-ESQ Parent	Parent	All Ages
Self Harming Thoughts and Behaviours	Clinician	All Ages
Assosiciated Difficulties	Clinician	All Ages

Every 6 months

C-GAS	Clinician	All Ages
Self Harming Thoughts and Behaviours	Clinician	All Ages
Assosiciated Difficulties	Clinician	All Ages

Yearly: Early Intervention Participants

All regular first assessment questionnaires	Self - Parent - Clinician	
Semi-Structured Interveiw	Self	12 to 18
Kidscreen-52 (Child and Adolescent)	Self	12 to 18
Kidscreen-52 (Parent)	Parent	12 to 18

Every Two years

Youth Self Report	Self	12 to 18
Gender Identity Interview (Natal M)	Self	12 to 18
Gender Identity Interview (Natal F)	Self	12 to 18
Utrecht Gender Dysphoria Scale (Natal M)	Self	12 to 18
Utrecht Gender Dysphoria Scale (Natal F)	Self	12 to 18
Body Image Scale (Natal M)	Self	12 to 18
Body Image Scale (Natal F)	Self	12 to 18
Recalled Childhood Gender Identity Scale (Natal M)	Self	12 to 18
Recalled Childhood Gender Identity Scale (Natal F)	Self	12 to 18
Child Behaviour Checklist	Parent	All Ages
Social Responsiveness Scale 2	Parent	All Ages
GIDS Questionnaire for Children (Natal M)	Parent	Under 12
GIDS Questionnaire for Children (Natal F)	Parent	Under 12
Teachers Report Form	Teacher	All Ages

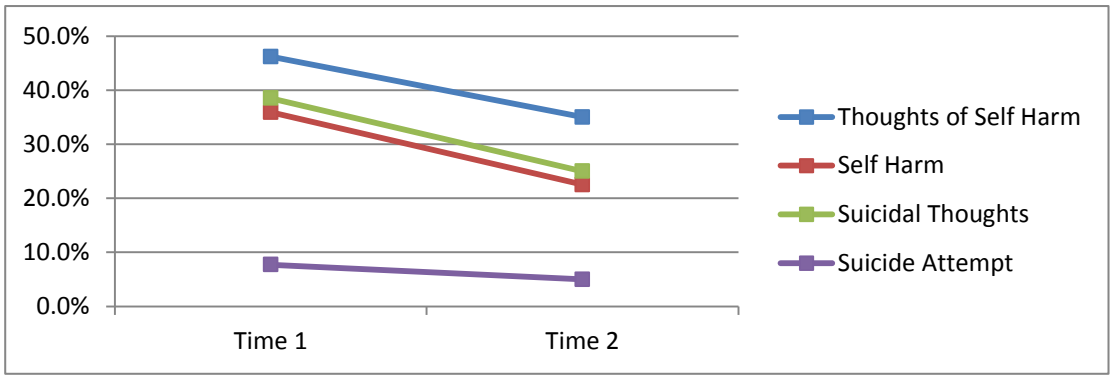
End of treatment

CHI-ESQ Child (9 - 11)	Self	9 to 11
CHI-ESQ Young Person (12 - 18)	Self	12 to 18
CHI-ESQ Parent	Parent	All Ages
Closing sheet	Clinician	All Ages

Appendix 5
Analysis of CGAS and Self Harm Outcome Measures

Self-Harm and Suicidal Thoughts Questionnaire Q1-Q4 2014-15 (repeated 6 monthly)

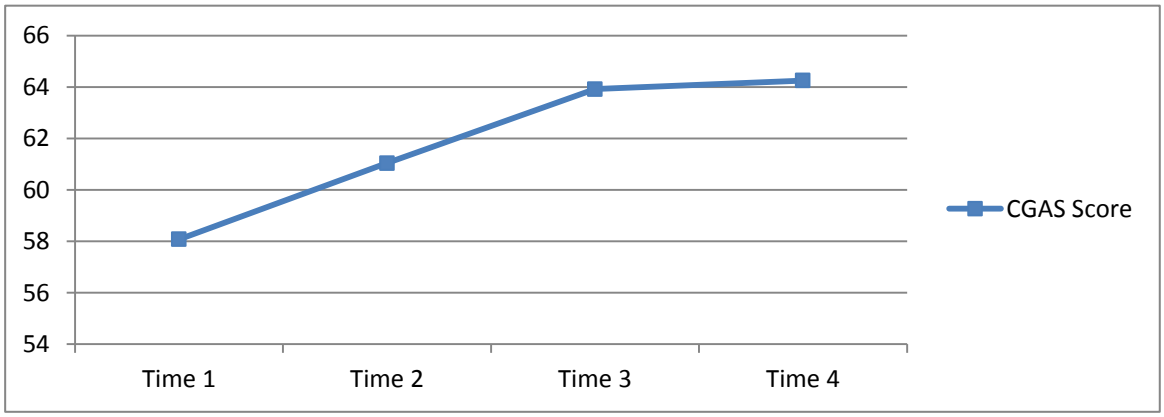
(n=40)	Time 1			Time 2			Improvement
	Yes	No		Yes	No		
Thoughts of Self Harm	46.2%	53.8%		35.0%	65.0%		+11%
Self Harm	35.9%	64.1%		22.5%	77.5%		+13%
Suicidal Thoughts	38.5%	61.5%		25.0%	75.0%		+14%
Suicide Attempt	7.7%	92.3%		5.0%	95.0%		+2.7%



The Self-harm and Injurious Thoughts Questionnaire is typically filled in by clinicians following the second assessment appointment and again 6 months later. In all four categories (Thoughts of Self Harm, Self-Harm Attempt, Thoughts of Suicide, Suicide Attempt), scores decreased between time one and tine two. Self-harm rates across the general population vary, but typically range between 8-18% (http://www.capmh.com/content/6/1/10)

Children's Global Assessment Scale Time 1-4 (6 monthly)

N=76	Time 1	Time 2	Time 3	Time 4
	58.08	61.04	63.92	64.25



This clinician rated assessment of general functioning is typically completed following the second assessment appointment and subsequently at 6 monthly intervals. The data presented above is that of service users who have had data collected at 4 time points. The data shows a general improvement in functioning, i.e. most patients moved from the category "Variable functioning with sporadic difficulties or symptoms in several social areas" to "Some difficulty in a single area but generally functioning pretty well" in the two year period.

Appendix 6
List of current Audit and Research Projects

Ethically approved research study looking at early pubertal suppression in a carefully selected group of children and adolescents

An international comparison of general well-being between English and Dutch young people presenting with Gender Dysphoria. This study was completes by a Dutch master's student for her thesis

Member of the team are developing research projects to look at:

- The association of eating disorder and gender dysphoria
- The impact of living in stealth on young people

An audit of body composition changes with patients on the blockers and cross sex hormones

An audit of persisting and desisting following referral and subsequent discharge from the service

An audit of the percentage of referrals who choose to undertake physical intervention

An audit on the efficiency of GnRH (blocker) suppression and an exploration of the potential association between the blocker and depression and anxiety

An audit of the long term effects of the blocker on bone density

An audit on the effects of cross-sex hormones on the immune system

Appendix 7
Preliminary Results from the Early Intervention Research

Results Early Intervention Research N=44

T0: Baseline (After Second / third appointment at the GIDS)

T1: 1 year on puberty suppression

Demographics:

No significant differences between natal boys and natal girls found in

1) Age referred to clinic 2) age starting puberty suppression, or 3) Time between start of puberty supression (GnRHa) and cross sex hormones (CSH)

Table 1: General characteristics

	All participants N = 44	Natal boys N = 24	Natal girls N = 20	*t* or χ^2	*df*	ρ
Age (in years) referred to Reserearch Project						
M (SD)	12.63 (.97)	12.45 (.83)	12.85 (1.09)	-1.35	42	0.196
Age start GnRHa						
M (SD)	13.16 (1.06)	13.13 (.99)	13.20 (1.15)	-0.232	42	0.676
Time (in years) between start GnRHa and CSH						
M (SD)	1.61 (.53)	1.56 (.56)	1.65 (.54)	-0.314	12	0.918

SRS: Autism questionnaire

No significant changes in Autistic traits in the participants between T0 and T1 on total T score and in SRS ranges.

Table; ASD traits measured by the SRS-2

	T0 (M,SD)	T1 (M,SD)	t / Z scoore	p
SRS total T score	62.31 (16.41)	62.66 (16.41)	-0.185	0.854
SRS Ranges %				
normal	53.30	41.40	-1.414	0.157
mid to moderate	30.00	37.90		
severe	16.70	20.70		

Psychological Functioning

Natal girls showed a significant increase in behavioural and emotional problems over time on mean *T*-scores of the internalizing scale on the CBCL (parent report), meaning: Natal girls showed more internalizing problems at T1 (1 year on puberty suppression) compared to T0 (before puberty suppression). However, according to the YSR (youth self-report) natal girls showed no significant changes in their internalising problems between T0 and T1.

Furthermore, the adolescents showed no significant changes in behavioural functioning over time measured by the parent report (CBCL), the self-report (YSR) and clinician report (CGAS) (see Table 2).

Table 2: Psychological functioning of adolescents with GD before (T0) and while on puberty supression (T1)

	T0			T1			T0 - T1 significance		Between-sex significance			
									Natal boys		Natal girls	
	All (N=30)	Natal boys (N=14)	Natal girls (N=16)	All (N=30)	Natal boys (N=14)	Natal girls (N=16)						
	M (SD)	*M (SD)*	*M (SD)*	*M (SD)*	*M (SD)*	*M (SD)*	*F (df, errdf)*	*ρ*	*F (df, errdf)*	*ρ*	*F (df, errdf)*	*ρ*
CBCL												
Total T-score	61.40 (10.84)	59.93 (12.99)	62.69 (8.77)	61.77 (10.27)	58.43 (11.88)	64.69 (7.87)	0.063 (1, 29)	0.804	0.334 (1,13)	0.573	1.733 (1,15)	0.208
Externalizing T-score	56.23 (12.29)	54.79 (13.85)	57.50 (11.04)	54.87 (11.69)	54.36 (13.72)	55.31 (10.02)	.800 (1, 29)	0.378	0.027 (1,13)	0.872	1.502 (1,15)	0.239
Internalizing T-score	60.57 (10.60)	59.43 (12.26)	61.56 (9.22)	62.93 (10.11)	59.29 (10.32)	66.13 (9.05)	1.703 (1, 29)	0.202	0.002 (1,13)	0.965	5.756 (1,15)	.030 *
YSR												
Total T-score	56.68 (9.75)	57.62 (11.59)	55.87 (8.17)	59.60 (11.77)	59.54 (14.12)	59.67 (9.80)	1.87 (1, 27)	0.183	0.295 (1,12)	0.597	2.035 (1,14)	0.176
Externalizing T-score	52.60 (10.60)	52.54 (11.98)	52.67 (9.70)	53.00 (11.82)	54.69 (13.84)	51.53 (10.02)	.040 (1, 27)	0.843	0.543 (1,12)	0.475	0.181 (1,14)	0.677
Internalizing T-score	55.68 (9.83)	57.54 (10.92)	54.07 (8.84)	60.50 (12.95)	60.38 (14.59)	60.60 (11.89)	3.70 (1, 27)	0.065	0.489 (1,12)	0.498	4.33 (1,14)	0.056
CGAS												
Global functioning	62.18 (2.04)	64.85 (11.43)	59.87 (10.01)	64.79 (1.72)	67.08 (10.95)	62.80 (6.89)	1.533 (1,27)	0.226	- 0.792 (1, 12)	0.444	- 0.925 (1,14)	0.371

M = Mean; SD = Standard deviation; CBCL = Child Behavior Checklist; YSR = Youth Self Report; CGAS = Children's Global Assessment Scale.

* Significant difference in mean between T0 and T1, $\rho < .05$

Clinical Range scores psychological functioning (measured by CBCL and YSR)

This table shows the percentages of adolescents scoring in the Normal, Borderline or Clinical range measured by the YSR (self-report) and CBCL (psychological functioning reported by their parents).

The percentage of adolescents scoring in the Clinical Range significantly decreased between T0 and T1, on the CBCL internalizing scale, meaning: according to their parents, the young people experience less internalizing behavioural problems following 1 year on puberty suppression treatment.
No significant changes were found between sexes (natal males & natal females).

Table 2a: Clinical Range scores from the CBCL and YSR

	T0			T1			T0 - T1 significance	
	Normal Range	Borderline Range	Clinical Range	Normal Range	Borderline Range	Clinical Range		
	%	%	%	%	%	%	*Z-score*	*ρ*
CBCL								
Total Problem score	46.70	13.30	40.00	33.30	13.30	53.30	-1.661	0.097
Externalizing Problem score	60.00	16.70	23.30	70.00	6.70	23.30	-0.64	0.522
Internalizing Problem score	50.00	13.30	36.70	33.30	3.30	63.30	-2.183	.029 *
YSR								
Total Problem score	60.00	6.70	33.30	50.00	14.30	35.70	-0.0589	0.55
Externalizing Problem score	70.00	16.70	13.30	71.40	10.70	17.90	0	1
Internalizing Problem score	63.30	16.70	20.00	46.40	14.30	39.30	-0.1942	0.052

Self-harm

Looking at two self-harm items measured by the YSR, a significant increase was found in the first item "I deliberately try to hurt or kill self". Adolescents had the option to score these items as: not true, sometimes true, often true. More adolescents tend to score this item in the "sometimes true - range" at T1 compared to T0, especially natal girls.

Table 4: Self harm items 18 and 91 from the Youth Self Report using Wilcoxon Test

	T0			T1			T0 - T1 significance		Between-sex significance			
	All N=30	Natal boys N=14	Natal girls N=16	All N=30	Natal boys N=14	Natal girls N=16			Natal boys		Natal girls	
	M (SD)	*M (SD)*	*M (SD)*	*M (SD)*	*M (SD)*	*M (SD)*	*Z*	*ρ*	*Z*	*ρ*	*Z*	*ρ*
Self harm items YSR:												
I deliberately try to hurt or kill myself	.13 (.15)	.14 (.36)	.13 (.34)	.39 (.56)	.23 (.44)	.50 (.63)	-2.111	0.035 *	0.447	6.55	-2.449	0.014 *
I think about killing myself	.30 (.53)	.21 (.43)	.38 (.62)	.57 (.73)	.43 (.65)	.69 (.79)	-1.734	0.083	-1.134	0.257	-1.311	0.19

* Significant difference in mean between T0 and T1, $\rho < .05$

This Table shows the percentages of the scores given in T0 and T1.

Table 3: Self-harm reported by adolescents at T0 and T1

	T0	T1
I deliberately try to hurt or kill myself		
not true	71.80%	67.90%
sometimes	18.90%	32.10%
often true	10.00%	0%
I think about killing myself		
not true	65.90%	58.60%
sometimes	29.60%	31.00%
often true	4.50%	10.30%

Gender Dysphoria & Body Image

No significant changes in gender dysphoria emerged, measured by UGDS, GII and RCGI. This suggests that the suppression of puberty does not impact positively on the experience of gender dysphoria. It will be interesting to see if the introduction of cross sex hormone produces different results.

For body image however, significant differences were found looking at both sexes separately between T0 and T1 (see Table 5). Natal boys were less dissatisfied with their primary sex characteristics after being on the blockers for 1 year ($F(1,12)=4.857$, $\rho<.05$), whereas natal girls appeared to be more dissatisfied with their secondary ($F(1,15)=5.509$, $\rho<.05$) and neutral sex characteristics ($F(1,15)=7.79$, $\rho<.05$).

Table 5: Gender Dysphoria and Body Image of adolescents before (T0) and 1 year on puberty supression (T1)

	T0			T1			T0 - T1 significance		Between-sex significance			
	All (N=30)	Natal boys (N=14)	Natal girls (N=16)	All (N=30)	Natal boys (N=14)	Natal girls (N=16)			Natal boys		Natal girls	
	M (SD)	*M (SD)*	*M (SD)*	*M (SD)*	*M (SD)*	*M (SD)*	*F (df, errdf)*	*ρ*	*F (df, errdf)*	*ρ*	*F (df, errdf)*	*ρ*
UGDS	4.77 (.24)	4.81 (.26)	4.74 (.22)	4.73 (.36)	4.76 (.39)	4.71 (.33)	.215 (1.29)	0.647	.159 (1,13)	0.697	.061 (1,15)	0.808
GII	2.03 (.27)	2.09 (.30)	1.98 (.24)	1.95 (.22)	2.05 (.16)	1.87 (.23)	1.740 (1,27)	0.198	.124 (1,13)	0.731	2.331 (1,14)	0.149
RCGI	2.02 (.43)	1.72 (.29)	2.26 (.38)	1.93 (.41)	1.67 (.29)	2.13 (.38)	1.860 (1,26)	0.184	0.17 (1,11)	0.688	2.703	0.122
Body Image Scale												
primary characteristics	4.49 (.47)	4.55 (.42)	4.44 (.51)	4.36 (.50)	4.17 (.51)	4.51 (.45)	1.445 (1,28)	0.239	4.857 (1,12)	0.048 *	0.387 (1,15)	0.543
secondary characteristics	2.96 (.70)	2.84 (.73)	3.06 (.69)	3.07 (.77)	2.53 (.76)	3.52 (.43)	.365 (1,28)	0.551	0.88 (1,12)	0.367	5.509 (1,15)	0.033 *
neutral characteristics	2.44 (.74)	2.71 (.65)	2.22 (.75)	2.70 (.68)	2.54 (.85)	2.82 (.50)	2.176 (1,28)	0.151	0.521 (1,12)	0.484	7.79 (1,15)	0.014 *

M = Mean; SD = Standard deviation; UGDS = "Utrecht Gender Dysphoria Scale"with Range 0-5; GII = "Gender Identity Interview" RCGI = "Recalled Childhood Gender Identity"

Body Image Scale is a 5-point scale coded with 1 = very satisfied to 5 = very dissatisfied with body part

* Significant difference in mean between T0 and T1, $\rho < .05$

Health and Well-being measured by the Kidscreen

The Kidscreen measures 10 dimensions of children's health and well-being, reported by parents and reported by the young person. Overall, no significant changes occurred in Health Related Quality of Life, except for one dimension completed by parents, which showed a significant decrease in Physical well-being of their child.

Table 6: Quality of Life measure for adolescents with GD before (T0) and while on puberty supression (T1) according to the KIDSCREEN

	T0			T1			T0 - T1 significance		Between-sex significance			
	All (N=30)	Natal boys (N=14)	Natal girls (N=16)	All (N=30)	Natal boys (N=14)	Natal girls (N=16)			Natal boys		Natal girls	
	M (SD)	*M (SD)*	*M (SD)*	*M (SD)*	*M (SD)*	*M (SD)*	*F (df, errdf)*	*ρ*	*F (df, errdf)*	*ρ*	*F (df, errdf)*	*ρ*
Kidscreen T-Values by Parents												
Physical Well-being	47.06 (11.37)	51.34 (12.07)	43.33 (9.57)	41.08 (11.44)	46.19 (5.08)	36.60 (13.60)	7.634 (1,29)	0.01 *	3.45 (1,13)	0.086	4.064 (1,15)	0.062
Psychological Well-being	40.64 (8.76)	40.82 (10.01)	40.48 (7.84)	40.01 (12.68)	45.19 (11.79)	35.48 (11.97)	.061 (1,29)	0.807	1.385 (1,13)	0.26	2.438 (1,15)	0.139
Moods and Emotions	43.49 (10.55)	42.37 (11.05)	44.47 (10.36)	42.50 (13.50)	47.71 (11.53)	37.95 (13.78)	.167 (1,29)	0.686	3.398 (1,13)	0.088	4.102 (1,15)	0.061
Self-Perception	35.46 (5.60)	33.93 (6.76)	36.79 (3.99)	33.78 (8.22)	33.84 (6.94)	33.73 (9.42)	.913 (1,29)	0.347	.001 (1,13)	0.971	1.600 (1,15)	0.225
Autonomy	47.54 (9.90)	48.75 (10.45)	46.48 (9.60)	46.56 (9.89)	48.62 (6.16)	44.77 (12.21)	.133 (1,29)	0.718	.002 (1,13)	0.97	.167 (1,15)	0.686
Parent Relation and Home Life	49.90 (10.88)	48.07 (8.95)	51.50 (12.40)	46.50 (12.21)	48.50 (12.22)	44.76 (12.34)	2.731 (1,29)	0.109	.044 (1,13)	0.838	4.307 (1,15)	0.056
Financial Resources	50.11 (9.64)	50.79 (9.51)	49.48 (10.06)	52.57 (12.60)	54.18 (11.65)	51.07 (13.67)	2.515 (1,28)	0.124	3.041 (1,13)	0.105	.426 (1,15)	0.525
Social Support and Peers	40.07 (10.57)	42.56 (7.76)	37.88 (12.36)	39.45 (14.11)	41.99 (12.28)	37.23 (15.58)	.061 (1,29)	0.807	0.025 (1,13)	0.876	.033 (1,15)	0.857
School Environment	45.91 (10.64)	47.66(7.75)	44.01 (13.24)	45.48 (12.09)	45.57 (10.23)	45.37 (14.37)	.030 (1,22)	0.864	0.939 (1,11)	0.353	.082 (1,10)	0.78
Social Acceptance and Bullying	37.77 (15.21)	31.88 (16.99)	42.93 (11.69)	35.67 (13.72)	33.55 (12.88)	37.53 (14.57)	.460 (1,29)	0.503	.131 (1,13)	0.723	1.705 (1,15)	0.211
Kidscreen T-Values by Adolescents												
Physical Well-being	43.61 (10.75)	44.84 (12.35)	42.63 (9.55)	40.66 (11.21)	45.05 (11.29)	37.09 (10.12)	1.260 (1,28)	0.271	.002 (1,12)	0.962	2.978 (1,15)	0.105
Psychological Well-being	43.63 (13.81)	41.46 (13.70)	45.39 (14.09)	40.26 (14.58)	43.02 (14.07)	38.01 (15.05)	1.128 (1,28)	0.297	.113 (1,12)	0.743	3.095 (1,15)	0.099
Moods and Emotions	44.26 (15.25)	42.45 (15.24)	45.83 (15.61)	40.91 (14.16)	42.37 (15.00)	39.64 (13.79)	1.005 (1,27)	0.325	.000 (1,12)	0.989	2.202 (1,14)	0.16
Self-Perception	34.30 (7.95)	34.58 (8.51)	34.07 (7.74)	36.15 (10.51)	36.53 (9.70)	35.83 (11.44)	.842 (1,28)	0.367	.442 (1,12)	0.519	.383 (1,15)	0.545
Autonomy	45.61 (10.66)	45.05 (9.28)	46.07 (11.95)	44.31 (13.31)	46.44 (12.46)	42.58 (14.12)	.261 (1,28)	0.614	.161 (1,12)	0.695	.907 (1,15)	0.356
Parent Relation and Home Life	51.27 (13.28)	49.41 (13.26)	52.78 (13.53)	49.27 (12.28)	51.04 (11.76)	47.83 (12.89)	.754 (1.28)	0.393	.280 (1,12)	0.606	2.347 (1,15)	0.146
Financial Resources	49.37 (11.16)	48.66 (9.16)	49.98 (12.94)	51.12 (11.69)	50.43 (12.30)	51.71 (11.53)	.493 (1,27)	0.489	.160 (1,12)	0.696	.387 (1,14)	0.544
Social Support and Peers	50.01 (10.00)	49.60 (12.24)	50.37 (8.02)	45.30 (15.32)	47.39 (16.57)	43.49 (14.47)	1.561 (1,27)	0.222	.121 (1,12)	0.734	2.307 (1,14)	0.151
School Environment	46.16 (15.26)	43.69 (13.52)	48.27 (15.04)	44.64 (15.73)	46.24 (13.49)	43.28 (17.81)	.192 (1,25)	0.665	.222 (1,11)	0.647	1.286 (1,13)	0.277
Social Acceptance and Bullying	40.97 (15.59)	33.87 (15.05)	46.29 (14.18)	41.79 (17.05)	40.34 (16.52)	42.88 (17.89)	.048 (1,27)	0.829	1.077 (1,11)	0.322	.559 (1,15)	0.466

Kidscreen items use 5-point Likert-type scales to assess either the frequency (never-seldomo-sometimes-often-always) of certain behaviors/feelings or intensity of an attitude (not at all-slightly-moderately-very-extremely)

T-values with a mean of 50 and a SD of 1-; higher scores indicate better HRQoL and well-being.

* Significant difference in mean between T0 and T1, $\rho < .05$

Appendix 8
List of papers published by GIDS Staff in the last year

Rosalia Costa, M. Colizzi, E. Skagerberg, M. Dunsford, V.Holt & P. Carmichael (2014) **Psychological support and puberty suppression improve psychosocial functioning in adolescents with gender dysphoria** (accepted, pending revisions)

Gregor, Hingley-Jones, Davidson (2014) **Understanding the Experience of Parents of Pre-pubescent Children with Gender Identity Issues**

Vicky Holt, Elin Skagerberg and Michael Dunsford (2014) **Young people with features of gender dysphoria: Demographics and associated difficulties** *Clin Child Psychol Psychiatry*

Senem Sahin, Vicky Holt (2014) **Presentation of Gender Dysphoria in Looked After and Adopted Children in the Gender Identity Development Service**

Elin Skagerberg, Domenico Di Ceglie, Polly Carmichael (2015) **Brief Report: Autistic Features in Children and Adolescents with Gender Dysphoria**

I Webb, E. Skagerberg, & Sarah Davidson (2014) **An investigation of body image satisfaction in young people: a comparison of persons with features of gender dysphoria and a non-clinical sample**

Wren B. (2015) In press. **A clinical service for gender non-conforming young people: what can a liberation psychology perspective contribute?** In T. Afuape & G. Hughes (Eds.): Towards emotional well-being through Liberation Practices: A dialogical approach.

Wren B (2015) In press. **'There is no room in Child and Adolescent Mental Health Services (CAMHS) for providing intervention without an evidence base': the case against.'** Context: the magazine for family therapy and systemic practice.

Wren, B. (2014) **'Thinking post-modern and practising in the Enlightenment': managing uncertainty in the treatment of transgendered adolescents**. Feminism and Psychology 24,2,271-291.

Appendix 9
Brief accounts from newer members of staff on their experience of joining/working with the Service

Garry Richardson, Senior (Principal) Social Worker:
Started February 2014

"I joined the team in February 2014 as a Specialist Senior Social Worker after a long period as a social work manager in a multi-disciplinary team in a Local Authority social care setting. I was excited to join the GIDS at such a dynamic time – the team was expanding to meet the ever growing demand for its service against the backdrop of massive advancements for the transgender movement and increasing awareness and debates about gender and gender diversity in society in general. My initial impression of the team was of a highly committed group of professionals working hard to assimilate these changes and cope with the challenges they bring whilst maintaining a high quality service to children, young people and their families. Much of my learning in this role has been 'on the job', which has meant a heavy reliance on the experience and guidance of my co-workers. My new colleagues were welcoming, approachable and hugely generous with both their time and knowledge. There are many challenges for the service, not least the demanding caseloads, which can feel overwhelming and a potential threat to the quality and level of work we are able to deliver. As a manager in the service I supervise three junior clinicians and a priority (and another challenge) for me is to ensure they receive adequate support in relation to the quantity and complexity of the work they take on. The infrastructure of the team is well managed and various forums and 'thinking spaces' are available and valued by both senior and junior members of the team alike. The clinical team also relies on the support of an incredibly hard working and professional administrative team. "

Hannah Waters, Clinical Psychologist
Started October 2013 as a Final year Clinical Psychology Doctoral Student and subsequently took up a Locum post in the service from September 2014

"I joined the team as a clinical psychology trainee in October 2013. I qualified a year later and I am currently hoping to gain a permanent

position in the team. I will write about my experience from my current perspective, as a newly qualified clinical psychologist.

Working in this team requires me to make use of all my skills as a psychologist. I conduct in depth assessments, work with individuals and families in the room, alter my approach to work with children as young as 5 and as old as 18 and formulate from many different models (CBT, narrative, social constructionist, systemic). I often have to respond therapeutically and creatively, in the moment, to whatever a client brings to the session. I think this can be unnerving for a newly qualified psychologist, but also quite liberating. My personal skills of engagement are vital as we have very little time to build a therapeutic relationship. Key to this role are the wider skills I use, such as consultancy. This was a particular challenge for me as a newly qualified psychologist as it requires a high level of professional confidence to be positioned as such an expert.

There are challenges to this work, in particular a very high caseload (around 90 currently), which can make it difficult to hold clients, their families and the professionals involved in mind. It can be frustrating not to be able to form strong therapeutic relationships due to the infrequency of appointments. Although our work is therapeutic, we do not have the resources to offer therapy, which can feel as though certain skills we have are at risk of becoming lost (e.g. CBT – I am a trained CBT therapist). We are a service who are in the public gaze and face a number of ethical dilemmas. This is part of the challenge of the role, and also what makes it so stimulating.

Despite the challenges I feel as though I am coping, despite not always feeling as though I have enough time to do everything I need to. Having some flexibility in working hours (i.e. time in lieu) is absolutely invaluable to be able to reach deadlines. I have developed in confidence since last year and I have felt more able to tolerate the high workload and to use the resource of the team to support me to make difficult treatment decisions.

This is a dynamic team with a focus on academic rigour and research, which I find stimulating. They are incredibly supportive. I would appreciate more time for psychological discussion and supervision, but I think this is something the team are aware of and we have invaluable clinical discussion groups. I also feel like this is a team who are receptive to suggestions from members of staff at all levels. As a national service

we are in a unique position to be able to consult to teams all over the country, which adds to the variety of the work and develops my skills and confidence as a professional."

Richard Parkin, Service Administrator
Started March 2014 on staff bank and subsequently took up a permanent post in the service from September 2014

"Finding myself in the Gender Identity Development Service without having any form of previous NHS experience (I came on as a temp and have since become permanent) has been a learning curve to say the least. From an administrative perspective there is still a real sense that the department is quite young and that can be seen in the way that our procedures and protocol are often changing or being streamlined, and the constant feeling that we need to increase our numbers to keep up with demand. The number of referrals seem to have increased dramatically even in the time I have been here (or at least it feels like it!) and the main challenge for the admin team is simply keeping up with this. Clinicians and admin staff alike seem to be feeling the strain. Alongside this we have to confront the problem that most of the people who call us for advice have very little options outside of waiting to be seen by our service and that can be difficult to convey to people in desperate need of help. However, given the specialist nature of the clientele and service, the clinicians in the team give up quite a lot of their time to respond to enquiries and offer advice to people whether or not they have been referred. Ultimately, in spite of sometimes feeling like we are drowning in paperwork and phone calls, I feel like I can always turn to literally any member of the team and ask for advice and Keyur will always respond almost immediately to any problem we throw at him."

Polly Carmichael
June 2015

Board of Directors : June 2015

Item : 10

Title : Annual Safeguarding Report 2015

Purpose:

This paper provides an update for the Board of Directors about safeguarding of children, young people and adults at risk in the Tavistock & Portman NHS Foundation Trust in the context of local and national developments.

This is the first report to the Board to include information about both safeguarding children and adults at risk.

This report has been reviewed by the Management Team on 11th June 2015

This report focuses on the following areas:

- Patient / User Experience
- Risk
- Quality

For : Discussion and noting

From: Rob Senior, Medical Director, Sarah Helps, safeguarding adults at risk lead, Sonia Appleby, named professional for child protection.

Annual Safeguarding Report, June 2015

Safeguarding adults at risk has risen in prominence on the national agenda more recently than the safeguarding of children and this is reflected in the different stages of development of the work in this Trust. However, the vulnerability of adults of all ages to exploitation and abuse, not just the elderly or those with a disability, is now better acknowledged and our practice and performance needs, increasingly, to reflect this.

SAFEGUARDING ADULTS AT RISK

1 Introduction

1.1 The national context for adult safeguarding is rapidly changing. Safeguarding is now seen as encompassing a wider brief than ever before and adult safeguarding concerns now have a similar level of importance as those regarding children. This is particularly the case in light of the abuses that adults, especially vulnerable adults, have been revealed to suffer in recent years.

1.2 Dr Sarah Helps has been in the role of adult safeguarding lead since the start of 2015. At the start of her time in role, she attended the NHS Executive training course for adult safeguarding leads, to enable her to develop an overview of the work and the role.

This brief report is structured according to the six Safeguarding principles:

2 Empowerment – the presumption of person led decisions and informed Consent

2.1 Dr Helps has completed four consultations regarding adult safeguarding issues since the start of 2015. One of the cases consulted about created a safeguarding alert / referral to the relevant local authority.
The consultations to date have focused on discussing how to address professional concerns when patients have the capacity to make their own decisions about their lives and how to provide patients with the information they need in order to make an informed decision about their situation.

2.2 The level of consultation about safeguarding concerns is currently low. There may be a culture of underreporting but this is probably attributable to our patient population being a relatively low-risk group and that many staff feel confident about adult safeguarding issues and so do not need to seek consultation.

3 Prevention - It is better to take action before harm occurs.

3.1 Knowledge, training and space to discuss dilemmas are key to the prevention of abuse. Training continues to be delivered at INSET days and at induction days.

3.2 A challenge in coming years is to help clinicians continue to have conversations with patients to support the prevention and early identification of abuse and neglect. The challenges of internet exploitation and radicalisation need careful ongoing consideration and staff need education to ensure that they know the questions to ask in order to assess safety and risk. An expanded range of questions to prompt clinicians to consider the range of potential safeguarding issues will soon appear on the new Initial Assessment form.

4 Proportionality – Proportionate and least intrusive response appropriate to the risk presented.

4.1 Consultations with staff have highlighted the importance of patients being supported to make their own decisions, even if professionals consider those to be unwise or unsafe decisions.

5 Protection - Support and representation for those in greatest need

5.1 Abuse can take many forms Physical (assault, GBH) Sexual (rape), Psychological, Neglect or acts of omission, Financial (theft/ fraud), Discriminatory (hate crime), Organisational, Self-neglect (including hoarding), Modern slavery (trafficking), Domestic abuse and Exploitation

5.2 As a trust we need to continue to educate ourselves especially regarding the forms of abuse that may be less familiar such as modern slavery and forms of exploitation.
We do not currently have any patients who are subject to DoLs (this would be very unlikely given the kind of services that we provide) or who lack capacity to make their own decisions regarding their treatment, although this information changes rapidly.

5.3 Clinicians have been offered robust training on the assessment of Mental Capacity and are becoming well-informed about how to assess and document concerns about capacity to make decisions about assessment and treatment

6 Partnership -Local solutions through services working with their communities.

6.1 Dr Helps now regularly attends the Camden Safeguarding Adults Partnership Board and so can share and contribute to local learning throughout the Trust.

7 Accountability -Accountability and transparency in delivering

safeguarding.

7.1 We regularly report figures on training and safeguarding alerts to external bodies, as these figures are increasingly part of data requested by commissioners.

8 Recommendations / actions for the 2015-2016

8.1 As we expand as an organisation, Trust safeguarding procedures may need to be varied according to the needs of each part of the organisation. Safeguarding procedures should be reassessed to meet the needs of each unit.

8.2 In order to contribute meaningfully to the Camden and Islington Safeguarding Adults Partnership Board Joint Adult Safeguarding Strategy Delivery Plan 2015-2016 the safeguarding adults at risk lead will ensure that safeguarding information and advice is made more accessible by regularly reminding staff that they can attend adult safeguarding training at level 1, 2 and 3,: by expanding the information held on line, in easy-read and video format and newsletters and by holding a regular forum in which to share safeguarding dilemmas and by visiting teams to discuss safeguarding dilemmas.

8.2 We will introduce a system to record potential safeguarding concerns in relation to self-neglect, exploitation and radicalisation as part of the initial and on-going assessment of patients, in a way that can be easily audited. Implementation to follow introduction of new IDCR in Q3.

SAFEGUARDING CHILDREN

This report follows the 2014 Safeguarding Children Report, which was presented to the Board in October 2014. This report will refer to events since then.

1. The local and national context

1.1 The external and internal drivers remain substantially unchanged but the scope and scale of the requirements we are expected to meet has increased. We need to ensure that service users and staff are in a safe environment and that the processes, practice and culture of the organisation promote and sustain effective safeguarding of children as central to the delivery of high quality services.

1.2 The immediate external environment is represented by commissioners' expectations, the strategic oversight by Camden Safeguarding Children Board (CSCB) and the supervisory functions of

the designated professionals, who continue to seek assurance via our reporting systems.

1.3 The Care Quality Commission and Ofsted continue to take a close and active interest in safeguarding practice at individual provider, multiagency and Borough level. As a Camden Provider, we will, in July 2015 be taking part in a second (within the last year) CSE inter-agency audit organised by Camden Children's Services and Camden Safeguarding Children Board (CSCB).

1.4 The CQC when they visit the Trust under the new model of inspection will inevitable take a close interest in our safeguarding performance.

1.5 NHS England and other specialist commissioners continue to take a heightened interest in safeguarding matters in areas such as the Portman and GIDS.

1.6 Health Education England and other commissioners of training and education increasingly seek assurance about safeguarding training and practice as do Higher Education Institutions who validate and quality assure our courses.

1.7 Changes in some Local Authority resources appear to have increased the demands on Trust staff. Children's Social Care services have changed their pathways and practices so that many community services now work with higher levels of risk. This has led to some concern from Trust staff about the safe management of case with attendant risk.

1.8 The recent publication of Kate Lampard's report on themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile places greater pressure on organisations to identify children and young people at risk of sexual exploitation and, concomitantly, to ensure organisational structures are more robust to deter and detect inappropriate individuals or groups gaining access to staff and services users.

1.9 The Goddard Inquiry into historical child abuse allegations will inevitably, and appropriately, lead to more victims coming forward and telling their stories, some for the first time. The Trust should anticipate an increase in adults seeking help to recover and manage the consequences of both their abuse and the processes linked to the inquiry.

2. Safeguarding Policy

2.2 The CQC Project Lead identified staff raising concerns about compliance with Trust safeguarding procedures when they were

working in settings that were also subject to the policies of another organisation. The Safeguarding Policy will be updated to confirm Trust staff are expected to be compliant with local and Trust safeguarding procedures.

2.3 In April 2015, a matter was escalated to the Designated Nurse in an outer London borough following their poor compliance in responding to a concern about a professional. The Safeguarding Policy will be revised to ensure staff, when making a referral about a professional, always confirm their concerns in writing.

2.4 The Safeguarding Policy will also be amended to reflect the changes regarding the term Local Authority Designated Officer (LADO), now being a defunct term in light of Working Together to Safeguard Children (March 2015).

2.5 The Safeguarding Policy will be revised to reflect the numbers of consultations where staff raise concerns about when to report historical abuse (usually sexual). The law may change in relation to mandatory reporting of disclosures and allegations. This may apply particularly when a person in authority in an organisation is made aware of allegations and fails to act as appears to have happened repeatedly with Jimmy Savile. In fact, it is more commonplace for service users to be reticent about giving any information that might identify the perpetrator. The following link will be included in the Safeguarding Report for Trust Staff:

http://www.bbc.co.uk/programmes/p0295l86

2.6 Finally, the Safeguarding Policy will reflect the changes in the safeguarding and training provision of Visiting Lecturers (VLs). VLs are accountable for not only ensuring they have a level of competence and knowledge regarding safeguarding children but that they also understand what to do if a safeguarding or child protection issue is raised within a lecture, tutorial, work discussion or supervision group. Essex University will require assurance on this and related issues as part of their validation and accreditation process for our courses.

3. Safer Recruitment

3.1 All staff with line management responsibility who might therefore be responsible for recruitment are required to complete the on-line safer recruitment training available at **elearning@nspcc.org.uk** . The current number of staff eligible for training including NEDs is 99. The total numbers of staff trained to date is 33. We do not know whether any of the staff who have not yet been trained have managed recruitment processes without having had training themselves or

ensuring that another member of the interview panel has had such training

3.2 The audit programme, postponed because of the changes within HR during Quarter 4 (2014/2015), will be conducted in quarter 3

4. Allegations against Staff

4.1 Since the October 2014 Report, there have been no reported allegations against staff.

5. Safeguarding Children Training

5.1 Training figures for Levels 1, 2, & 3 remain above the KPI for this domain.

Safeguarding Training Data to date, 2015/16

April 2015					
	Total numbers requiring training	**Number of staff trained**	**Number of staff NOT trained**	**%**	**Rational (Reason for non-attendance)**
Level 1	503	476	27	95%	16 excused - 12 from November INSET Day (sick/just returned from Mat leave/other appointments) (4 excused from February Induction - 1 personal reason (Bereavement) / 3 staff on 2 day external conference)
Level 2	48	46	2	96%	2 booked for Sept next Level 2 training
Level 3	293	272	21	92%	13 new starters (2 based in Leeds) - 4 returned from MAT/CB - 1 Leaving the Trust - 3 booked May - July) . The one senior staff in CAMHS who is leaving the Trust should have attended the training by April 15 but did not and they have not been exempted either therefore given they will be onsite until end of July we will flag this up with their manager.

May 2015					
	Total numbers requiring training	**Number of staff trained**	**Number of staff NOT trained**	**%**	**Rational (Reason for non-attendance)**

Level 1	505	471	34	93%	5 new starters (sick/ booked on course/did not sign in/on annual leave) 29 (9 excused from May INSET Day/returned from MAT/CB/off sick/1 query secondment/2 based elsewhere/ 2 leaving in next few months one exempted but the rationale for other is as above level 3)
Level 2	48	47	1	98%	1 booked to attend Level 2 training in September
Level 3	312	269	43	86%	12 new starters - 1 based in Leeds) - 4 returned MAT leave/ 26 booked June - September - 1 secondee query raised with CAMHS manager as to the date they will leave the Trust and if that will necessitate attendance.

5.2 It is anticipated there is likely to be a lower trough in the rate of training for 2015 -2016. This reflects the original safeguarding programme where most staff were trained in 2009. Thus, in 2012/2013, too many staff required training virtually all at the same time and this impacted on the numbers of trained staff decreasing for at least one Quarter.

5.3 To mitigate the possibility of lower training rates, HR will be calling some staff for refresher training earlier than required; the Named Professional will be offering more team-based training and staff will be continually encouraged to access multi-agency (external) course programmes.

6. Audits

6.1 A limited audit in January 2015 using a self-report tool into whether staff who are working with children or young people subject to Child Protection Plans (CPPs) received safeguarding supervision revealed that the majority reported that they did but evidence from the case notes indicated that this was only infrequently recorded. We will be rolling out a child protection supervision record and providing team managers with a termly, supervision forum to think in depth about safeguarding and child protection.

6.2 As mentioned above, as a Camden Provider, we will, in July 2015 be taking part in a second (within the last year) CSE inter-agency audit organised by Camden Children's Services and Camden Safeguarding Children Board (CSCB).

7. New Safeguarding Performance Indicators

7.1 There is a new local CQUIN regarding domestic violence – an issue associated with substantial risks of harm to children in the household - with two elements:

- To develop a systematic approach to the identification of domestic violence, support and referral to appropriate services.
- To develop a training programme for front line staff on awareness, identification, support and prevention.

7.2 A lead has been appointed and a draft document has been circulated.

Dr Rob Senior

June 2015

Board of Directors : June 2015

Item : 11

Title : Board of Directors Objectives 2015/16

Purpose:

This paper sets out the proposed objectives for the Board of Directors for 2015/16.

These objectives have come out of the work being done on the 2 year strategic plan.

The Board is asked to consider and approve these objectives, which will form the basis of individual objectives to be agreed at a later date.

For : Approval

From : Trust Chair

Board Objectives, June 2015

Objective	Details	Review Date
STRATEGY		
Publish refreshed medium term strategy for the Trust	Publish refreshed statement of mission and values. Set ambitions for next five years. Agree detailed roadmap for the next two years. Agree and monitor refreshed BAF which is aligned with the medium term strategy. Agree basis for monitoring progress against the strategy.	July 2015
Oversee development of the Trust's role in children and young peoples' mental health and of existing services in line with new service models.	Oversee strengthening existing provision through introduction of Thrive model. Support growth of a leadership role through development of Thrive Partnership. Support securing of opportunities to extend CAMHS service provision. Oversee quality of existing services through scrutiny of CQSG and service line reports.	Ongoing
Oversee develop and improve Adult and Forensic services	Encourage development of services which integrate mental and physical health, building on success of City and Hackney and TAP. Encourage development of services for people with personality disorder Agree strategy for the future of the Portman Clinic Oversee quality of existing services through scrutiny of CQSG and service line reports.	Ongoing
Workforce Development – ensure the Trust has sufficient well trained staff to provide high quality and cost effective services	Engage in a review of staffing structures, ensuring the banding of roles and levels of seniority meet clinical need and value for money. Ensure training development provision is in place to support succession planning and strategy requirements, and disseminate research findings and best practice. Ensure staffing concerns are listened to and an atmosphere of openness is promoted.	Autumn 2015
Oversee the development of the	Increase our role in delivery of research	Ongoing

Trust's role in research		
Agree an OBC for the development of our accommodation	Make outline decisions about accommodation options	September 2015.
PERFORMANCE		
Oversee significant progress in developing the scale and effectiveness of the Trust's Training and Education activities.	Set and monitor targets for growth of student numbers and income. Set plan to increase the national reach of the Trust's education and training work including a robust Regional partnership strategy. Set priorities and targets for new course development. Agree proposals to improve effectiveness and efficiency of the Trust's delivery operations for training and education processes, including marketing, recruitment and technology enhanced learning. Hold Training and Education Programme Board to account for operational delivery of training and education activities.	Ongoing
Encourage a step change in our organisational effectiveness and performance	Oversee effectiveness implementation of Care Notes. Promote the better use of data across the organisation to manage performance and support service development. Support attempts to raise the profile of the organisation and its work including the project with Century Films. Work to ensure engagement with staff and to develop leadership across Trust. Ensure the Trust maintains a green rating from Monitor on Governance.	Ongoing
Oversee the Trust's financial performance and ensure all key financial duties are met.	Oversee delivery of agreed budget for 2015/6. Oversee plans for development of balanced budget for 2016/7 and agreement of medium term financial strategy. Ensure all required financial duties are met Maintain a Continuity of Service risk rating of 3 or above	Ongoing
QUALITY		
Oversee the quality of the Trust's activities.	Oversee Trust's preparation for CQC inspection Encourage staff to raise concerns. Support plans to ensure voice of lived experience and patients more mainstream	Ongoing

	Challenge the organisation in relation to the contribution it makes to improve the mental health of excluded and vulnerable communities. Hold CQSG to account in its oversight of quality in the organisation.	
GOVERNANCE		
Ensure the BoD supports the recruitment and induction of the new Chair and Governors	Support the CoG led appointment of a new Chair Facilitate an appropriate induction for the new Chair Support elections of new Governors, facilitate induction for them and use joint meetings to develop relationship between board and council.	Summer 2015 Autumn 2015 Autumn 2015.
Recruit for NED in Spring 2016	Support Governors in recruitment for a new NED in Spring 2016, with a focus on finance/business experience	Spring 2016

Paul Jenkins, CEO
Angela Greatley, Chair
June 2015

Board of Directors : June 2015

Item : 12

Title : Update on Chair Recruitment

Summary:

This report updates the Board on progress with the Chair recruitment process.

This report has been reviewed by the following Committees:
- Management Team, 11th June 2015

This report focuses on the following areas:

- Corporate Governance

For : Noting

From : Gervase Campbell, Trust Secretary

Update on Chair Recruitment

1. Introduction

1.1 Our current Chair's term of office will end on the 31st October, and we are in the process of recruiting a new Chair to start on the 1st November.

1.2 This is a Governor led appointment, and the Chair Appointment Committee has been meeting over the course of this year to decide the details of the recruitment process.

1.3 The post was advertised at the end of May, and closed on the 19th June.

1.4 The advert was placed in the Sunday Times, the Guardian, non-execs.com (a website run by the Financial Times), NHS Jobs, our website, and publicised via networks.

2. Timetable

2.1 The Committee will meet to shortlist applications on the 14th July
2.2 There will be an opportunity for shortlisted candidates to meet senior members of the Trust at the end of July and over August.
2.3 Candidates will give presentations to a selected group of staff and governors on the 7th September. Feedback from this will be collated and given to the interview panel on the following day.
2.4 The interviews will be held on the 8th September.
2.5 The Council will meet on the 17th September to consider the recommendation of the committee and make the appointment.

3. Presentations

3.1 The candidates will be invited to give a presentation of 10 minutes to a selected audience and then to lead a discussion on the topic for a further 20 minutes.
3.2 Feedback will be collated and given to the interview panel by Dr Sally Hodges.
3.3 The audience for the presentations will be approximately 25 people, comprising Governors, board members, externally and Tavistock based staff, patients and carers, students and representatives from the University of Essex. HR will work to arrange the audience once the number of Governors who wish to attend has been agreed, which will be at the June Council meeting.

4. Interviews

4.1 The interview panel will be:

- Mr Mark Pearce, Governor, Chair of Committee
- Patient Representative
- Ms Mary Burd, Governor
- Ms Natalie Baron, Governor
- Ms Anthony Levy, Govenor
- Mr Paul Jenkins, CEO
- Mr David Holt, NED

4.1.1 Dr Hodges is working to identify a patient representative to join the panel, and they will be invited to take part in the shortlisting and will be briefed by the chair and have the opportunity to meet the other members of the panel in advance to ensure they feel fully involved in the process.

5. Interest in the role

5.1 At the time of writing the Trust Secretary had discussed the role with approximately 20 people, the majority of whom seemed to be credible candidates.

Gervase Campbell
Trust Secretary
June 2015

Board of Directors : June 2015

Item : 13

Title : Identity Badges

Summary:

Currently, a minority of Trust staff have identity badges. This is now out of line with practice in the majority of NHS services. The CQC Steering Group raised the issue as to whether all staff should now be required to have identity badges in considering our response to the Safety Key Line of Enquiry.

This report focuses on the following areas:

- Quality
- Patient / User Experience
- Patient / User Safety
- Equality
- Risk
- Finance

For : Discussion

From : Director of Quality and Patient Experience

IDENTITY BADGES

1. Introduction

1.1 Currently, a minority of Trust staff have identity badges. This is now out of line with practice in the majority of NHS services. The CQC Steering Group raised the issue as to whether all staff should now be required to have identity badges in considering our response to the Safety Key Line of Enquiry.

1.2 The CQC do not put an obligation on the Trust to issue identity badges, but given that this would be expected in the majority of health services inspected, our Trust would need to have clear and well-evidenced arguments for the benefits of not issuing badges to all staff.

1.3 Service users should be able to easily identify staff members and staff should be able to prove that they are bona fide members of staff. These issues have become more salient in the light of the Savile recommendations, which require Trusts to take measures to protect patients, vulnerable children and adults from abuse.

1.4 To date, the Trust has operated with two systems, one where some front of house staff and those working in the community are required to hold ID, whilst the majority of staff based at the Tavistock Centre and the Portman Clinic are not required to hold ID. We have argued in the past that there are advantages for service users in terms of reducing stigma through our not identifying staff.

1.5 Service users have been consulted through two visual straw polls. Both polls showed that the majority of respondents did not support the routine use of ID badges for staff. However, this result does not mean that the majority of all service users would prefer staff not to use ID badges.

1.6 The Human Resources Department issues identity badges to clinical and non-clinical staff, including honorary staff, when these are specifically requested by the relevant line manager and are generally issued when staff work front of house or regularly work at, or visit, other sites. Additionally, doctors are now issued with identity badges from their start date for Pharmacy use. These identity badges comply with the prescribed NHS format and include the individual's photograph.

1.7 At present, approximately 135 of the Trust's 560 staff have identity badges. This leaves approximately 75% of Trust staff without identity badges.

1.8 At the Management Team meeting on 19th March 2015, it was agreed that identity badges would be issued to all staff. All staff, clinical and non-clinical, should have a badge to show who they are and to prove

that they are a staff member. The badge can be the standard NHS issue badge on a lanyard, which could have 'Hello, my name is…' on it to make it more service user friendly.

1.9 There could also be more informal badge, which can be pinned to clothing and might just provide a name and title, without the photo identification required for the standard NHS ID badge.

1.10 Rationale for the use of ID badges for all staff and honorary staff:

- To prove identity and that the badge-holder is a bona fide member of staff.
- To ensure that patients, carers and service users can easily identify us as staff and by name and role.
- Patients and service users in many health care settings complain that staff do not introduce themselves and that they do not know who to ask for help. These complaints have not been reported in our services.

1.11 It is not proposed that staff will need to wear identity badges at all times, but should be able to produce them whenever requested to do so. Therefore, the use of ID badges should not impinge on clinical practice where this might have a detrimental impact.

2. Access and ID

2.1 The issuing of ID badges should be treated separately from questions of access. We do not propose that staff use ID to gain access to Trust facilities.

2.2 The question of who requires visitor's passes and whether changes should be made to access security to the buildings used by the Trust should be addressed separately. Security issues have been reviewed in the past and no changes to current practice was recommended. However, we might wish to reconsider.

3. Logistics and Costs

3.1 A further question was raised as to whether identity badges should also be issued to those on honorary contracts (approximately 130 people) and to current Visiting Lecturers (approximately 150 people). When added to Trust staff, this makes approximately 700 people requiring identity badges (not including the requirement to produce badges for all new starters on an on-going basis).

3.2 The Human Resources Department has one identity badge printer which, because of its age, is unreliable, hard to repair and the software is difficult to update. With the volume of identity badges to be

produced, a new printer will be required. As a guide, a quote has been obtained, which is £1,848.92 (this includes sufficient consumables to print 1,000 identity badges).

3.3 The Human Resources Department estimates that it takes approximately fifteen minutes to produce each identity badge. This gives a total of approximately 175 hours to produce the 700 identity badges (this will require an estimated resources of three months at Band 4 = £8,100) to undertake this one-off exercise. This does not take account of the practicalities of getting the 700 staff to attend the Human Resources Department to get their photographs taken.

3.4 The system will also need to be maintained on an on-going basis to capture new starters and leavers. This will require resources of 0.5 wte Band 4 at a cost of £16,200.

3.5 For new starters, the recruitment process will need to be amended to incorporate staff attending the Human Resources Department to get their photographs taken and to have their identity badges produced before they start work.

3.6 For staff leaving the Trust, a process will need to be designed for the return of identity badges.

3.7 Staff on short term contracts and bank staff would need temporary identity badges.

4. Considerations

4.1 Should students be issued with identity badges and, if so, why?

4.2 Would it make sense to buy two identity badge printers; one to be located in HR and the other in DET (for the Visiting Lecturers)?

4.3 Do we need an identity card policy?

5. Timescale

5.1 It is anticipated that this exercise could commence in August 2015, with a December 2015 completion date.

Board of Directors : June 2015

Item : 14

Title : Corporate Governance Statement – declaration of compliance with conditions of our licence from Monitor.

Summary:

Monitor require us to complete an annual self-certification declaring whether the Trust is compliant with aspects of the Risk Assessment Framework (RAF), appendix E of the RAF, and section s151(s) of the Health and Social Care Act.

The Board of Directors is invited to approve the statements, which are attached.

This was reviewed by the Management Team on 11th June 2015

This report focuses on the following areas:

- Quality
- Risk
- Finance

For : Approval

From : Simon Young, Deputy Chief Executive and Director of Finance

Corporate Governance Statement

1. Introduction

1.1 For submission to Monitor by the end of June, the Board of Directors is required to consider 8 statements covering compliance with our licence conditions; and to confirm or not confirm each of the statements.

2. Statements in declaration

2.1 The following sections give the text of each of the statements. The Board of Directors is invited to confirm all 8 statements.

2.2 The first statement: "The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS."

2.2.1 The board of directors is invited to confirm this statement on the basis of: the system of committees, such as CQSG and audit, which report to the board, combined with the assurance framework and risk register, to give assurance.

2.2.2 A more detailed description is given in the Annual Governance Statement which was approved by the Audit Committee and the Board last month, as part of the Annual Report.

2.3 The second statement: "The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time"

2.3.1 The board of directors is invited to confirm this statement on the basis of: the director of finance, the trust secretary and the chief executive receive guidance from Monitor and ensure that it is implemented within the Trust.

2.4 The third statement: "The Board is satisfied that the Trust implements:
(a) Effective board and committee structures;
(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
(c) Clear reporting lines and accountabilities throughout its organisation."

2.4.1 The board of directors is invited to confirm this statement on the basis of: the effectiveness of our system of internal control is assessed by our internal and external auditors, each committee of the board assesses its own effectiveness, and the functioning of the board, including its relationship to its committees, is assessed annually.

2.4.2 Again, more detail is given in the Annual Governance Statement.

2.5 The fourth statement: "The Board is satisfied that the Trust effectively implements systems and/or processes:
(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;
(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;
(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;
(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
(h) To ensure compliance with all applicable legal requirements."

2.5.1 The board of directors is invited to confirm this statement on the basis of: the existing system of internal controls, committees and the assurance framework and risk register which give assurance to the board.

2.5.2 Again, more detail is given in the Annual Governance Statement.

2.6 The fifth statement: "The Board is satisfied that the systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:
(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;

(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;
(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
(e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
(f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate."

2.6.1 The board of directors is invited to confirm this statement on the basis of: the regular reports and assurance from the CQSG to the board, the annual Quality Report and complaints report, and the regular service line reports which are brought to the board.

2.6.2 Again, more detail is given in the Annual Governance Statement.

2.7 The sixth statement: "The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence."

2.7.1 The board of directors is invited to confirm this statement on the basis of: the reports of the annual board assessment, the annual appraisals conducted for all board members and senior directors.

2.8 The seventh statement concerns trusts which are, or are considering becoming, part of a major Joint Venture or Academic Health Science Centre. The AHSC we belong to does not have control over any part of the Trust's business or resources; and we are not part of any other major Joint Venture. The requirements of this statement therefore do not apply to us, and it can be completed as 'Confirmed'.

2.9 The eighth statement: "The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role."

2.9.1 The paragraph of the Act referred to reads, "A public benefit corporation must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such."

2.9.2 The board of directors is invited to confirm this statement on the basis of: in the past year training courses have been offered externally with Governwell on a range of topics. Additionally, we have offered Information Governance training, and arranged visits to clinical services, as well as providing details of Trust events such as scientific meetings which governors are welcome to attend.

3. Views of the Governors

3.1 In approving the statements, we can confirm that we have taken the views of the governors into account. The Board is consulting the Council of Governors during the development of the strategic plan. The Council of Governors also receives reports on the matters covered by these statements, including the annual letter from the external auditors, which is being considered at the meeting on 25th June; and representative members of the Council take part in the governance processes of the Trust.

3.2 Governors take part in several key committees in the Trust's governance structures. In addition this year, the Council of Governors agreed the competitive process for appointment of auditors; one Governor joined the selection panel; and the recommendation of the panel will be presented to the Council for approval on 25th June.

Simon Young
Deputy Chief Executive and Director of Finance

Board of Directors : June 2015

Item : 15

Title : Terms of Reference of the Audit Committee

Summary:

The Audit Committee has reviewed its ToR and proposes some minor changes, which are presented for approval.

For : Approval

From : Chair of the Audit Committee

The Tavistock and Portman NHS
NHS Foundation Trust

Audit Committee

Terms of Reference

Ratified by:	Board of Directors
Date ratified (current version):	June 2014
Name of originator/author:	David Holt, Committee Chair
Name of responsible committee/individual:	Audit Committee / Committee Chair
Date issued (current version):	May 2015
Review date:	May 2016

Audit Committee
Terms of Reference

1. Constitution

1.1 The Board of Directors hereby resolves to establish a Committee to be known as the Audit Committee (the Committee). This Committee has no executive powers other than those delegated in these terms of reference.

2. Membership

2.1 The Audit Committee will be appointed by the Board of Directors.

2.2 All members of the Committee should be independent Non-Executive Directors of the Trust. For the avoidance of doubt, the Trust Chair shall not be a member of the Committee.

2.3 The Committee shall consist of at least three members.

2.4 The Board should appoint the Chair of the Audit Committee from amongst its independent Non-Executive Directors.

2.5 At least one member of the Audit Committee should have recent and relevant financial experience.

3. Attendance

3.1 The Director of Finance and appropriate External and Internal Audit representatives shall normally attend meetings.

3.2 At least once a year the External and Internal Auditors shall be offered an opportunity to report to the Committee any concerns they may have in the absence of all Executive Directors and officers. This need not be at the same meeting.

3.3 The Chief Executive and other Executive Directors shall attend Committee meetings by invitation only. This shall be required particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Director. When an internal audit report or other report shows significant shortcomings in an area of the Trust's operations, the Director responsible will normally be required to attend in order to respond to the report.

3.4 The Chief Executive should be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

3.5 The Local Counter Fraud Specialist shall attend to agree a work programme and report on their work as required.

4. Quorum

4.1 This shall be at least two members.

5. Frequency of meetings

5.1 The Committee shall meet at least four times per year.

5.2 The external or internal auditor may request a meeting when they consider it necessary.

6. Secretary

6.1 A Secretary shall be appointed for the Audit Committee.

7. Agenda & Papers

7.1 Meetings of the Committee will be called by the Committee Chair. The agenda will be drafted by the Committee Secretary and approved by the Committee Chair prior to circulation.

7.2 Notification of the meeting, location, time and agenda will be forwarded to Committee members, and others called to attend, at least five days before the meeting. Supporting papers will also be sent out at this time. If draft minutes from the previous meeting have not been circulated in advance then they will be forwarded to Committee members at the same time as the agenda.

8. Minutes of the Meeting

8.1 The Committee Secretary will minute proceedings, action points, and resolutions of all meetings of the Committee, including recording names of those present and in attendance.

8.2 Approved minutes will be forwarded to the Board of Directors for noting.

8.3 In advance of the next meeting, the minutes and the log of action points will be circulated to all involved, so that the action log can be updated and included in the papers for the meeting.

9. Authority

9.1 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek information it requires from any employee, and all employees are directed to co-operate with any request made by the Committee.

9.2 The Committee is authorised to obtain outside legal advice or other professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary.

10. Duties

10.1 Governance, Risk Management and Internal Control

10.1.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives

10.1.2 In particular, the Committee will review the adequacy of:

10.1.2.1 all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the Care Quality Commission's *Judgement Framework*), together with any accompanying Head of Internal Audit statement, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors

10.1.2.2 the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

10.1.2.3 the policies for ensuring compliance with relevant regulatory, legal, and code of conduct requirements in conjunction with the Clinical Quality, Safety, and Governance Committee

10.1.2.4 the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Protect~~the Counter Fraud and Security Management Service~~

10.1.2.5 the financial systems

10.1.2.6 the Internal and External Audit services, and counter fraud services

10.1.2.7 compliance with *Board of Directors' Standing Orders* (BDSOs) and *Standing Financial Instructions* (SFIs)

10.1.3 The Committee should review the Assurance Framework process on a periodic basis, at least twice in each year, in respect of the following:

- the process for the completion and up-dating of the Assurance Framework;
- the relevance and quality of the assurances received;
- whether assurances received have been appropriately mapped to individual committee's or officers to ensure that they receive the due consideration that is required; and
- Whether the Assurance Framework remains relevant and effective for the organisation.

10.1.4 The Committee shall review the arrangements by which Trust staff can raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety, or other matters. The Committee should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

10.1.5 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, External Audit, the Local Counter-Fraud Service, and other assurance functions. It will also seek reports and assurances from Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

10.1.6 The Committee shall review at each meeting a s~~S~~chedule~~s~~ of ~~material~~ debtors balances ~~should be reviewed~~, with ~~those~~ material debtors more than six months requiring explanations/action plans.

~~10.1.6~~10.1.7 The Committee shall review at each meeting a report of tenders and tender waivers since the previous meeting.

10.2 Internal Audit

10.2.1 The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory ~~NHS~~ Public Sector Internal

Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and Board of Directors. This will be achieved by:

10.2.1.1 consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal

10.2.1.2 review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework

10.2.1.3 consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the Internal and External Auditors to optimise audit resources

10.2.1.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation

10.2.1.5 monitoring and assessing the role of and effectiveness of the internal audit function on an annual basis in the overall context of the Trust's risk management framework

10.2.1.6 ensuring that previous internal audit recommendations are followed up on a regular basis to ensure their timely implementation

10.3 External Audit

10.3.1 The Committee shall review the work and findings of the External Auditor appointed by the Board of Governors, and consider the implications and management's responses to their work. This will be achieved by:

10.3.1.1 approval of the remuneration to be paid to the External Auditor in respect of the audit services provided

10.3.1.2 consideration of recommendations to the Board of Governors relating to the appointment and performance of the External Auditor

10.3.1.3 discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensuring co-ordination, as appropriate, with other External Auditors in the local health economy

10.3.1.4 discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee

10.3.1.5 review all External Audit reports and any work carried out outside the annual audit plan, together with the appropriateness of management responses

10.4 Other Assurance Functions

10.4.1 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the Trust

10.4.2 These will include, but will not be limited to, any reviews by Monitor, Department of Health Arm's Length Bodies or Regulators / Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

10.4.3 In addition, the Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. Particularly with the Clinical Quality, Safety, and Governance Committee, it will meet at least annually with the Chair and/or members of that Committee to assure itself of the processes being followed.

10.4.4 In reviewing the work of the Clinical Quality, Safety, and Governance Committee, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

10.4.5 The Audit Committee should incorporate within its schedule a review of the underlying processes for the Information Governance Toolkit and the Quality Accounts production to be able to provide assurance to the Board that these processes are operating effectively prior to disclosure statements being produced.

10.5 Management

10.5.1 The Committee shall request and review reports and ~~positive~~ assurances from Directors and managers on the overall arrangements for governance, risk management and internal control

10.5.2 They may also request specific reports from individual functions within the Trust (e.g. clinical audit) as they may be appropriate to the overall arrangements

10.6 Financial Reporting

10.6.1 The Committee shall review the Annual Report and Financial Statements before submission to the Board of Directors, focusing particularly on:

10.6.1.1 the wording in the ~~Statement on Internal Control~~Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee

10.6.1.2 changes in, and compliance with, accounting policies and practices

10.6.1.3 unadjusted mis-statements in the financial statements

10.6.1.4 major judgemental areas

10.6.1.5 significant adjustments resulting from the audit

10.6.2 The Committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board of Directors

10.7 Appointment, reappointment, and removal of external auditors

10.7.1 The Committee shall make recommendations to the ~~Board~~ Council of Governors, in relation to the setting of criteria for appointing, re-appointing, and removing External Auditors

10.7.2 The Committee shall make recommendations to the ~~Board~~ Council of Governors, in relation to the appointment, reappointment, and removal of the External Auditors, providing the ~~Board~~ Council of Governors with information on the performance of the External Auditor

10.7.3 The Committee shall approve the remuneration and terms of engagement of the External Auditors

11. Other Matters

11.1 At least once a year the Committee will review its own performance, constitution and Terms of Reference to ensure that it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board of Directors for approval.

11.2 The Committee should consider holding a discussion at the end of some meetings with regards to the effectiveness of the committee, considering those areas highlighted within this paper.

12. Sources of Information

12.1 The Committee will receive and consider minutes from the Clinical Quality, Safety, and Governance Committee. The Committee will receive and consider other sources of information from the Director of Finance.

13. Reporting

13.1 The minutes of the Committee, once approved by the Committee, will be submitted to the Board of Directors for noting. The Committee Chair shall draw the attention of the Audit Committee or the Board of Directors to any issues in the minutes that require disclosure or executive action.

13.2 The Committee will report annually to the Board of Directors on its work in support of the Annual Governance Statement , specifically commenting on the completeness and integration of risk management in the Trust, the integration of governance arrangements, and the appropriateness of the self-assessment against the Care Quality Commission's *Judgement Framework*.

13.3 The Committee Chair shall attend the Annual General Meeting (AGM) prepared to respond to any Member's questions on the Committee's activities.

Board of Directors : June 2015

Item : 16

Title : Scheme of Delegation of Powers Review 2015

Summary:

This document outlines amendments made to the Scheme of Delegation of Powers. The Scheme was reviewed by the Trust Secretary, with only minor changes needing to be made since the 2014 review.

This report has been reviewed by the following Committees:

- Management Team, 11th June 2015.

This report focuses on the following areas:
(delete where not applicable)

- Risk
- Corporate Governance

For : Approval

From : Gervase Campbell, Trust Secretary

Scheme of Delegation of Powers Review 2015

1. Introduction

1.1 The scheme was reviewed in 2014 and a number of changes were made. This year there have been few changes, mostly just to the titles of staff involved.

2. Names of those with delegated authority

2.1.1 The titles of CAMHS and SAMHS directors were updated to the Director of Children, Young Adults and Family Services (CYAF) and the Director of Adult and Forensic Services (AFS).

3. Delegated matters

3.1 (5d) Opening Tenders

3.1.1 The list of Designated Officers for opening tenders, agreed by the CEO, added to 'Other' section.

Gervase Campbell
Trust Secretary
4th June 2014

Delegated Matter			Reference documents & notes	Chief Executive	Finance Director	Medical Director	Director of Q&PE	Dean	Director of Human Resources	Dir. of Corp. Gov. & Facilities	Commercial Director	Trust Secretary	Directors of CYAF/AFS	Line / Dept Manager	Procurement Manager	Budget Holder	Petty Cash Holder	Other
1. Management of budgets	Responsibility of keeping expenditure within budget		SFI 3													■		
2. Maintenance / operation of bank accounts			SFI 5		■													
3. Non-pay revenue and capital expenditure / requisitioning / ordering / payment of goods and services	a) Requisitions		SFI 9															Any individual authorised by Budget Holder and Deputy Director of Finance
	b) Purchase orders		SFI 9												■	■		
	c) Invoices not covered by a purchase order															■		Any Individual authorised by Budget
4. Capital schemes	a) selection of architects, quantity surveyors, consultant engineers, and other professional advisors, within EU regulations								■									Estates Officer
	b) financial monitoring and reporting on all capital scheme expenditure				■				■									
5. Quotation and Tendering Procedures (see also 3(e) above)	a) Obtaining 3 written quotations on the basis of a written specification for goods / services from £10,000 to £60,000		SFI Appendix 6;												■	■		Other originating Officer
	b) Obtaining at least 3 written competitive tenders for goods/services above £60,000		SFI Appendix 4; SFI Appendix 5													■		
	c) Waiving of the requirements to obtain quotations or tenders subject to SFIs		SFI Appendix 4.3; SFI Appendix 6.3	■	■													
	d) Opening Tenders		SFI Appendix 5.3; **Note:** Any two Executive Directors, in presence of Trust Secretary	■	■	■	■	■				■						Any two exec. Directors or managers on the list of Designated Officers.
	e) Retaining records	(i) Retaining the *Register of Tenders*	Constitution Annex 5									■						
		(ii) Retaining detailed records of each tender	SFI Appendix 5.3															Originating Department
		(iii) Retaining records of competitive quotations obtained	SFI Appendix 6.2; SFI Appendix 6.3												■			Originating Department
6. Contracts for NHS Clinical Services	a) Setting prices		SFI 7; SFI 6.2		■					■								

Must authorise Must jointly authorise May authorise with approval

Delegated Matter			Reference documents & notes	Chief Executive	Finance Director	Medical Director	Director of Q&PE	Dean	Director of Human Resources	Dir. of Corp. Gov. & Facilities	Commercial Director	Trust Secretary	Directors of CYAF/AFS	Line / Dept Manager	Procurement Manager	Budget Holder	Petty Cash Holder	Other
(6. Contracts for NHS Clinical Services continued…)	b) Signing agreements																	Director of CYAF/ Director of AFS
7. Setting of Fees for Training courses, Consultancy work and other services	a) New training courses		SFI 6.2															
	b) Annual review of fees for all courses																	Management Team
	c) Daily fee rates (range) to be charged for all consultancy work																	Director of Tavistock Consulting
	d) Approval of fees for other services including the Glouceter House Day Unit etc.																	Unit Directors
8. Expenditure of Charitable Funds	a) From grants received for specific purposes (e.g. research grants; donations for specific services)		SFI 16; Charitable Fund Cttee ToR															
	b) From staff earnings funds																	
	c) From all other funds:	(i) Up to £20,000																
		(ii) Above £20,000																Charitable Fund Committee
9. Agreements/Licences	a) Letting of premises to, or renting of premises from, outside organisations		SFI 6.2.4															
	b) Approval of rents to be charged		SFI 9.2.7.1 **Note:** to be based on professional assessment and subject to competitive tendering requirements															
10. Condemning & Disposal - items which are obsolete, obsolescent, redundant, irreparable or which cannot be repaired cost effectively	a) with current / estimated purchase price under £200		SFI 13; SFI Appendix 11															
	b) with current purchase new price over £200 but expected sale value and current book value (where applicable) both under £1,000																	Head of IM&T
	c) with expected sale value or current book value (where applicable) both over £1,000																	
	d) with expected sale value or current book value (where applicable) both over £5,000		**Note:** Subject also to competitive quotations or tendering															

Must authorise Must jointly authorise May authorise with approval

Delegated Matter			Reference documents & notes	Chief Executive	Chief Executive	Finance Director	Medical Director	Director of Q&PE	Dean	Director of Human Resources	Dir. of Corp. Gov. & Facilities	Commercial Director	Trust Secretary	Directors of CYAF/AFS	Line / Dept Manager	Procurement Manager	Budget Holder	Petty Cash Holder
11. Losses, Write-offs & Compensation	a) Losses due to theft, fraud, overpayment & others Up to £50,000		SFI 13.2; HM Treasury "Managing Public Money"															
	b) Fruitless Payments (including abandoned Capital Schemes) Up to £50,000																	
	c) Bad Debts and Claims Abandoned up to £50,000																	
	d) Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use, up to £50,000																	
	e) Compensation payments made under legal obligation (no limit)																	
	f) Extra Contractual payments to contractors, up to £50,000																	
	g) Ex-gratia payments to patients and staff for loss of personal effects:	(i) Less than £100																
		(ii) Between £100 and £50,000																
	h) Ex-gratia payments for clinical negligence up to £50,000 (including plaintiff's costs) for negotiated settlements following legal advice and in compliance with guidance																	
	i) Ex-gratia payments for personal injury claims involving negligence, up to £50,000 (including plaintiff's costs), where legal advice has been obtained and guidance applied																	

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Delegated Matter			Reference documents & notes	Chief Executive	Finance Director	Medical Director	Director of Q&PE	Dean	Director of Human Resources	Dir. of Corp. Gov. & Facilities	Commercial Director	Trust Secretary	Directors of CYAF/AFS	Line / Dept Manager	Procurement Manager	Budget Holder	Petty Cash Holder	Other
(11. Losses, Write-offs & Compensation continued…)	j) Other ex-gratia payments, up to £50,000 (but note that the Trust has no delegated authority to make any payments in cases of maladministration where there was no financial loss by the claimant)																	
12. Reporting of Incidents to the Police	a) Where a fraud is suspected		SFI 13.2; Counter Fraud Policy															
	b) Violence, theft or any other offence or suspicion		SFI 13.2															Governance & Risk Lead or Receptionist
13. Petty Cash Disbursements	a) Expenditure up to £50		SFI 9.2.8; **Note:** Items which cannot be covered from petty cash floats are to be submitted as cheque requests (e.g. for long distance patient fares) or invoices approved for payment)															
	b) Expenditure above £50 and up to £100 per item																	Financial Controller
14. Ensuring that Internal and External Audit, and Local Counter Fraud Specialist recommendations are implemented			SFI 2															Relevant Director
15. Maintenance & Update of Trust Financial Procedures			SFI 3.3															
16. Investment of Funds	a) The Trust's Exchequer funds.		SFI 10.2; Operating Cash Management Policy															
	b) Charitable funds		SFI 16; Charitable Fund Cttee ToR															Charitable Fund Committee
17. Application to the Department of Health for Advance of Public Dividend Capital			SFI 10.1; Operating Cash Management Policy; **Note:** Any two Executive Directors are required															Any two exec. Directors.

Must authorise Must jointly authorise May authorise with approval

Delegated Matter			Reference documents & notes	Chief Executive	Finance Director	Medical Director	Director of Q&PE	Dean	Director of Human Resources	Dir. of Corp. Gov. & Facilities	Commercial Director	Trust Secretary	Directors of CYAF/AFS	Line / Dept Manager	Procurement Manager	Budget Holder	Petty Cash Holder	Other
18. Borrowing			SFI 10.1; Trust's Operating Cash Management Policy															
19. Human Resources & Pay	a) Authority to fill funded post on the establishment with permanent staff.		Policy & Procedure for Recruitment & Selection															
	b) Authority to appoint staff to long-term post not on the formal establishment.		SFI 8.2.3; Policy & Procedure for Recruitment & Selection															
	c) Additional Increments - The granting of additional increments to staff within budget *on appointment.*		Agenda for Change Conditions of Service															
	d) Banding, rebanding, and other remuneration matters - All requests shall be dealt with in accordance with Trust Procedure:	(i) Staff listed in "Duties (1)" of the Remuneration Committee Terms of Reference	Remuneration Cttee ToR															Remuneration Committee
		(ii) All other staff	Policy & Procedure for Recruitment & Selection															
	e) Establishments:	(i) Additional staff to the agreed establishment with specific external funding	SFI 8															
		(ii) Additional staff to the agreed establishment without specific external funding																
	f) Pay:	(i) Authority to complete standing data forms affecting pay, new starters, variations and leavers	SFI 8															HR Officer
		(ii) Authority to authorise overtime																
		(iii) Authority to authorise travel & subsistence expenses																
		(iv) Approval of Performance Related Pay Assessment	Remuneration Cttee ToR															Remuneration Committee
	g) Leave:	(i) Approval of annual leave	NHS Terms and Conditions of Service Handbook; Other relevant terms & conditions of service; Leave Policy															

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Delegated Matter			Reference documents & notes	Chief Executive	Finance Director	Medical Director	Director of Q&PE	Dean	Director of Human Resources	Dir. of Corp. Gov. & Facilities	Commercial Director	Trust Secretary	Directors of CYAF/AFS	Line / Dept Manager	Procurement Manager	Budget Holder	Petty Cash Holder	Other
(19 Human Resources & Pay continued…)	(g) Leave continued...)	(ii) Annual leave - approval of carry forward (up to 5 days or in the case of Ancillary & Maintenance staff as defined in their initial conditions of service).																
		(iii) Annual leave - approval of carry over in excess of 5 days.																Director of relevant directorate
		(iv) Compassionate leave																
		(v) Special leave arrangements																
		(vi) Leave without pay																
		(vii) Time off in lieu (to be documented)																
		(viii) Maternity Leave - paid and unpaid																HR Officer
	h) Sickness Absence:	(i) Extension of sick pay on half pay up to three months	Trust Sickness Absence & Rehabilitation Policy & Procedure															
		(ii) Return to work part-time on full pay to assist recovery, phased return to work advised by OH	Trust Sickness Absence & Rehabilitation Policy & Procedure;															
		(iii) Extension of sickness absence on full pay																
	i) Study Leave:	(i) Medical staff study leave	Leave Policy															
		(ii) All other study leave																
	j) Grievance Procedure - All grievances cases must be dealt with strictly in accordance with the Grievance Procedure		Grievance Policy & Procedure															
	k) Authorised Mobile Device Users - Requests for new posts to be authorised as mobile telephone users		Mobile Phone & PDA Agreement															
	l) Renewal of Fixed Term Contract																	

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Delegated Matter			Reference documents & notes	Chief Executive	Finance Director	Medical Director	Director of Q&PE	Dean	Director of Human Resources	Dir. of Corp. Gov. & Facilities	Commercial Director	Trust Secretary	Directors of CYAF/AFS	Line / Dept Manager	Procurement Manager	Budget Holder	Petty Cash Holder	Other
	n) Redundancy		Redundancy & Redeployment Policy & Procedure	■					■									Chief Executive and Remuneration Committee for senior staff
	o) Ill Health Retirement - Decision to pursue retirement on the grounds of ill-health								■									
	p) Dismissal		Disciplinary Policy & Procedures															Dismissal Officer
20. Authorisation of Sponsorship deals				■														Management Committee
21. Authorisation of Research Projects						■												Director of Research & Development
22. Authorisation of Clinical Trials						■												Director of Research & Development
23. Insurance Policies and Risk Management			SFI 18	■	■					■								
24. Patients & Relatives Complaints	a) Overall responsibility for ensuring that all complaints are dealt with effectively		Trust Policy and Procedure for the Management of Formal Complaints															Complaints Officer
	b) Responsibility for ensuring complaints relating to a department are investigated thoroughly											■						Relevant Director
	c) Management of the legal aspects of complaints									■								
25. Relationship with the media			Media Policy	■														Director of Marketing and Communications
26. Patient Services	Variation of clinic sessions			■								■						
27. Facilities for staff not employed by the Trust to gain practical experience	a) Professional Recognition, Honorary Contracts, & Insurance of Medical Staff.								■			■						
	b) Work experience students								■									
28. Review of fire precautions			Fire Safety Procedures							■								
29. Review of all statutory compliance with legislation on health and safety			Health & Safety Policy							■								
30. Review of *Medicines Inspectorate Regulations*						■												

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Delegated Matter			Reference documents & notes	Chief Executive	Finance Director	Medical Director	Director of Q&PE	Dean	Director of Human Resources	Dir. of Corp. Gov. & Facilities	Commercial Director	Trust Secretary	Directors of CYAF/AFS	Line / Dept Manager	Procurement Manager	Budget Holder	Petty Cash Holder	Other
31. Review of compliance with environmental regulations																		
32. Review of Trust's compliance with the *Data Protection Act*			Data Protection Policy															Information Governance Lead; Senior Information Risk Owner
33. Review the Trust's compliance with the *Access to Records Act*			Trust Procedure for the Management of Health Care Records															
34. Membership management and Governor elections			Constitution															
35. The keeping of registers for the *Declaration of Interests*, the register of members and the *Declaration of Independence*			Constitution, Annex 5															
36. Attestation of sealings in accordance with Standing Orders			BDSO 9															Or Officers nominated by CEO and FD
37. The keeping of a register of sealings, and reporting to the Board of Directors			BDSO 9															
38. The keeping of the *Gifts and Hospitality Register*			SFI 20															
39. Information Governance			SFI 17; Information Governance Policy															Information Governance Manager; Senior Information Risk Owner; Caldicott Guardian
40. Clinical Governance																		
41. Review of the Trust's compliance with Monitor's *Code of Governance*			Monitor's Code of Governance															
42. Review of the Trust's compliance with Monitor's *Compliance Framework*	a) Financial matters		Monitor's Compliance Framework															
	b) Governance declaration																	
	c) Membership matters																	
43. Review of the Trust's compliance with the *Codes of Conduct for the Board of Directors and the Board of Governors*			Board of Directors' Code of Conduct; Board of Governors' Code of Conduct															
44. The review and keeping of the *Assurance Framework* and *Risk Register*	a) Strategic Risk Register																	
	b) Operational Risk Register																	

Must authorise Must jointly authorise May authorise with approval

BOARD OF DIRECTORS (PART 1)

Meeting in public
Tuesday 23rd June 2015, 14.00 – 16.40
Board Room, Tavistock Centre, 120 Belsize Lane, London NW3 5BA

AGENDA

PRELIMINARIES				
1.	**Chair's Opening Remarks** Ms Angela Greatley, Trust Chair		Verbal	-
2.	**Apologies for absence and declarations of interest** Ms Angela Greatley, Trust Chair	To note	Verbal	-
3.	**Minutes of the previous meeting** Ms Angela Greatley, Trust Chair	To approve	Enc.	p.1
3a.	**Outstanding Actions** Ms Angela Greatley, Trust Chair	To note	Enc.	p. 10
4.	**Matters arising** Ms Angela Greatley, Trust Chair	To note	Verbal	-
REPORTS & FINANCE				
5.	**Trust Chair's and NEDs' Report** Non-Executive Directors as appropriate	To note	Verbal	-
6.	**Chief Executive's Report** Mr Paul Jenkins, Chief Executive	To note	Enc.	p. 11
7.	**Finance & Performance Report** Mr Simon Young, Deputy Chief Executive & Director of Finance	To note	Enc.	p. 14
8.	**Training and Education Report** Mr Brian Rock, Director of Education & Training; Dean	To note	Enc.	p. 22
9.	**Service Line Report, GIDS** Dr Polly Carmichael, Director of GIDS	To note	Enc.	p. 26
10.	**Annual Safeguarding Report** Dr Rob Senior, Medical Director	To note	Enc.	p. 60
STRATEGY				
11.	**Board Objectives** Ms Angela Greatly, Chair; Mr Paul Jenkins, CEO	To approve	Enc.	p. 69
12.	**Update on Chair Recruitment** Mr Gervase Campbell, Trust Secretary	To note	Enc.	p. 73
13.	**Identity Badges** Ms Louise Lyon, Director of Q&PE	To discuss	Enc.	p. 76

CORPORATE GOVERNANCE				
14.	**2nd Monitor Self-Certificate** Mr Simon Young, Deputy Chief Executive & Director of Finance	To approve	Enc.	p. 80
15.	**Audit Committee Terms of Reference** Mr David Holt, Audit Chair	To approve	Enc.	p. 85
16.	**Scheme of Delegation of Powers Review** Mr Gervase Campbell, Trust Secretary	To approve	Enc.	p. 95
PATIENT STORY				
17.	**Patient Story - GIDS** Ms Claire Shaw, Patient Story Lead	To discuss	Verbal	-
CONCLUSION				
18.	**Any Other Business**		Verbal	-
23.	**Notice of Future Meetings** • Thursday 25th June 2015: Council of Governors' Meeting 2.00pm – 5.00pm, Board Room • Tuesday 14th July 2015: Leadership Group 12.00pm – 5.00pm, Lecture Theatre • Tuesday 28th July 2015: Board of Directors' Meeting 2.00pm – 5.00pm, Board Room		Verbal	-